

Dr Vasanth and Partners

Quality Report

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Date of inspection visit: 24 March 2016

Date of publication: 04/08/2016

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?

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 Dr Vasanth and Partners on March 24 2016. 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. Opportunities for learning from internal and external incidents were identified and acted on.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice engaged with Wigan Clinical Commissioning Group (CCG) peer review process to develop their safeguarding toolkit and improve treatment pathways for patients with asthma and chronic obstructive pulmonary disease.

- Feedback from patients about their care was consistently positive. Patients we spoke with were passionate about the level of care provided.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had a clear clinical governance and leadership structure.
- There was a continual and proactive focus on staff professional development.

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.

Good



- The practice had a culture of openness when encouraging staff to submit incident reports. Senior staff investigated these appropriately and used the findings to improve care and service. Staff worked within a 'no blame' culture, which was embedded through the use of an up to date policy.
- There was a consistent focus on safeguarding at all levels of the practice. This included the safeguarding of vulnerable adults and of children. Staff had appropriate safeguarding training and worked closely with local safeguarding teams to escalate any concerns. The practice had a safeguarding lead and a deputy.
- Medicines were stored, managed and prescribed according to national best practice guidance. The practice worked with a medicines management technician to conduct an annual audit of repeat prescriptions to ensure prescriptions were safe and appropriate.
- The practice was visibly clean and demonstrated a high level of infection control through consistently good performance in monthly audits.

Are services effective?

The practice is rated as good for providing effective services

Good



- Our findings at inspection showed that systems were in place to ensure that practice met both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- Clinical staff worked proactively with patients at risk of unplanned hospital admissions to reduce their presentation at emergency departments.
- Care and treatment in the practice was monitored using the Quality and Outcomes Framework (QOF). QOF is the annual reward and incentive programme detailing GP practice achievement results. Patient outcomes demonstrated high compliance with QOF requirements.
- Effective systems were in place to support patients who were in vulnerable circumstances.
- Staff were encouraged and supported to take additional specialist training courses as part of their professional development, such as in the management of diabetes, COPD, postnatal depression and infertility.

Summary of findings

- Clinical staff worked to a consent policy that enabled them to protect the rights of the individual whilst ensuring they had the mental capacity to provide consent.
- Health promotion support and signposting provided for patients included smoking cessation, weight management and the reduction of anxiety and depression.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- All of the patients we spoke with described a caring, responsive and compassionate team of staff who involved them consistently in decisions about their care and treatment.
- Palliative care in the practice was described by patients and relatives as particularly good and staff demonstrated a compassionate approach to ensuring people had the best quality of life possible when they chose not to have invasive emergency treatment.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice had an active patient participation group (PPG) who met on a quarterly basis with the lead GP and practice manager. Staff consulted this group on changes to practice.
- Staff demonstrated an exceptional understanding of the diverse needs of the local population.
- Emergency appointments were available for parents with new born babies or young children and the lead GP offered flexible appointments for vulnerable people.
- Local deprivation indicators were used by clinical staff to ensure individual needs were met for vulnerable people such as those experiencing unemployment or homelessness.
- Extensive, detailed information was available in printed format for patients on a range of common conditions to help them self-manage these and direct access contact details for 17 local service providers had been prepared for people.
- The practice aimed to ensure equitable access for everyone. This included hearing loops in key patient areas, disabled access to the building, the availability of sign language and other spoken language interpreters
- Patients can access appointments and services in a way and at a time that suits them. This included early morning, evening and Saturday appointments.

Summary of findings

- Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

- The practice had a clear vision with quality and safety as its priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The culture of the practice encouraged staff to suggest small changes that could positively impact patient experience and the working environment.
- Clinical governance arrangements were adequate and practices were assessed against a comprehensive internal quality assurance system that was actively monitored by the practice manager.
- Practice meetings and GP forums were used to discuss clinical governance and care planning relating to individual patients.
- We saw evidence learning from meetings was used to improve patient care.
- Practice staff actively engaged with patients through the PPG, responding to individual feedback and the practice satisfaction survey.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

Good



- The practice nurse provided health checks for new patients over the age of 75.
- Staff prioritised appointments and care for patients at the end of life on the palliative care register. This included liaising with the Hospital at Home team to provide individualised care.
- People were offered an annual 'health MOT', which was a comprehensive health check to support people to improve their daily quality of life.
- Staff liaised with the community dietician to ensure malnourishment prevention was appropriate amongst elderly patients.
- Elderly patients who needed chronic disease management as well as those who were housebound were provided with homecare arrangements. This included individual treatment reviews, blood tests and immunisations at home.

People with long term conditions

The practice is rated as good for this population group.

Good



- The practice had a higher number of patients with long-term conditions than the England average, at 64%.
- Patients were prescribed repeat prescriptions after being assessed for safety using an established repeat prescriptions policy. Each patient on long-term medication was given an annual medication review.
- Weekly chronic disease clinics were used to support people with long-term blood pressure conditions; diabetes; asthma; epilepsy; chronic obstructive pulmonary disease (COPD) and thyroid disease.
- Patients with long-term conditions were cared for using structured care plans, which were regularly reviewed to make sure they continually met the person's needs.
- Patients with diabetes could be referred to a Diabetes Education and Self-Management for Ongoing and Diagnosed (DESMOND) education course to empower them to increase control over their diagnosis.
- Clinical staff ensured patients with long-term conditions had access to multidisciplinary professionals where necessary and

Summary of findings

were involved in their own care planning and treatment decisions. This enabled them to focus on their immediate quality of life and make informed choices about future care and treatment.

- A health trainer was available in the practice on a weekly basis and supported people with conditions such as anxiety, weight loss and smoking cessation.
- A local medicines management pharmacy team had recently reviewed all of the practice's patients who lived in a care home. The two teams met following the review and identified areas for improvement in medicines management.
- Staff followed local antibiotic prescribing guidelines and pro-actively monitored prescriptions.

Families, children and young people

The practice is rated as good for this population group.

- The practice provided directed enhanced services in childhood vaccination and immunisation. This meant children in the practice catchment area benefitted from recommended immunisation courses and recommended reinforcing doses.
- Clinical staff understood new housing the area meant there were more young families within the practice catchment area. To address the lead GP had implemented a same-day emergency triage system for the parents of babies and young children and offered extended ad-hoc hours in the early morning and evening.
- The practice nurse offered six appointments each week for childhood immunisations.
- A GP-led postnatal clinic was offered on a weekly basis with availability for six appointments. A GP had undertaken additional training in the management of antenatal and postnatal depression.
- Weekly clinics were available in ante-natal and post-natal care with a midwife and young mothers were able to secure an appointment the same day if they had concerns about the health of their new born baby.
- The practice nurse provided health checks for new born babies.
- Patients had access to a sexual health clinic in the same building as the GP practice and could access this through an open referral from the GP.
- The practice followed guidance from the CCG in improving appointment access times for parents with young children. A

Good



Summary of findings

priority system had been implemented which meant a GP could triage the child by telephone and then see them in the practice the same day. This helped to reduce unnecessary hospital attendances.

- Appointments for children were offered outside of local school opening hours to promote school attendance.
- One of the practice GPs had worked with couples interested in infertility treatments, successfully supporting one couple through the fertility treatment process to a successful birth.

Working age people (including those recently retired and students)

The practice is rated as good for this population group.

- The lead GP offered ad-hoc early morning and evening appointments for people whose work commitments made it difficult for them to attend during regular opening times.
- The practice saw a lower number of working age people in employment than the England average at 50% and a higher than average number of patients were unemployed. Staff had a good understanding of the health promotion needs of this patient group including in relation to anxiety and depression, alcohol and drug use and broader social care needs.
- Weekly clinics were available for cervical smears, travel immunisation and smoking cessation.
- Staff had an understanding of the needs of working age people who found themselves homeless. This included liaising with community support workers, community link workers and specialist liaison teams to ensure patients were appropriately signposted and cared for.
- GPs could issue an open referral to the sexual health clinic in the same building, providing a faster service for patients.
- A comprehensive guide to local NHS services was available at reception to guide people to the most appropriate location for their concern, such as the pharmacy, walk-in centre for direct access services such as podiatry.
- The practice offered an online and fax prescription service, which increased convenience as it meant patients did not need to visit the practice to collect it.
- Staff used the pharmacy minor ailments scheme to increase access for patients who were away from home.
- The practice used electronic fit notes to allow patients to alter their working hours while resuming work after illness.

Good



People whose circumstances may make them vulnerable

The practice is rated as outstanding for this population group.

Outstanding



Summary of findings

- The practice provided directed enhanced services in reducing unplanned hospital admissions. This meant clinical staff ensured patients at high risk of emergency department attendance were identified and supported appropriately through timely, urgent access to appointments.
- The practice nurse supported people who had a learning disability that made them vulnerable in the community.
- Where staff considered a patient with a long-term condition to be at risk of a safeguarding issue, this was documented in their care plan and was reviewed regularly.
- Clinical staff promoted contact with patients who were in vulnerable circumstances. This increased the contact time between patients and a GP because the flexible approach meant the patient could request help as circumstances allowed.
- Staff were responsive to patients with drug dependency who would sometimes arrive unannounced at the practice. The GP saw the patients opportunistically to ensure they received timely medication and avoided an unnecessary emergency hospital attendance.
- Staff arranged for a sign language interpreter for deaf patients and also engaged with the special senses social worker to improve communication and equitable access.
- A GP worked closely with an alcohol detox centre and community alcohol worker to support patients with alcohol dependency. This included a two-weekly GP-led review prior to the prescribing of medication used for their recovery.
- The practice maintained a learning disability register validated against the community learning disability register.
- A community link worker visited the practice once a week to support people with complex social needs and risks, such as homelessness and people under probation orders related to alcohol dependency.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for this population group.

- The practice provided directed enhanced services in facilitating timely diagnosis and support for people with dementia. This meant staff proactively offered assessments to patients at risk of dementia and worked to improve the quality of care they received.
- From April 2014 to March 2015, 79% of patients diagnosed with dementia had received a face-to-face review.

Good



Summary of findings

- Staff proactively managed the needs of patients living with schizophrenia, bipolar affective disorder and other psychoses by working with them to establish a comprehensive care plan. This was completed in 90% of cases in April 2014 to March 2015, which was the latest period of data available to us.
- Weekly clinics were held for patients with mental health needs and learning disabilities.
- Patients with a mental health illness, including dementia, were cared for using a structured care plan, which was reviewed regularly. Care plans were individualised and were used to make sure people's changing needs were identified and met.
- A counselling room was available in the practice, which was decorated in colours that reduced levels of stimulation. Staff used this room to speak with patients with anxiety and they were also offered this room as a waiting area if the main reception area was too busy or noisy for them. Where a patient experienced anxiety from busy or noisy environments, the lead GP made a note of this in their records for when they attended hospital appointments. This meant where possible hospital staff would provide a separate quiet space for the patient to wait.
- Patients at risk of self-harm were prescribed weekly scripts using dossette boxes to reduce the risk of overdose.

Summary of findings

What people who use the service say

The latest national GP patient survey results for this provider were published in January 2016. The results showed the practice was performing in line with or above local and national averages. 399 survey forms were distributed and 103 were returned. This represented 4% of the practice's patient list.

- 82% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 97% of patients described the overall experience of this GP practice as good compared to the national average of 85%.

- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we asked for CQC comment cards to be made available to patients prior to our inspection. We received 20 comment cards which were all positive about the standard of care received. People commented they felt listened to consistently by all staff in the practice and said they felt treated as individuals. Comments showed us people were happy to be registered with the practice on a long-term basis because of the individualised care they received. Several people commented they felt staff exceeded their expectations, including reception staff, the practice nurse and GPs.

Areas for improvement

Action the service **SHOULD** take to improve

- Some administration staff did not have appropriate infection control training although we saw evidence this was being addressed by the practice manager.
- There was no lone working policy in place to protect staff against the risks of working one-to-one out of hours with patients when no other staff were present.

Outstanding practice

- The practice demonstrated that it had developed high quality and innovative framework in which it provided care to patients who were in vulnerable circumstances. This work had a positive impact on these patients.

Dr Vasanth and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, who was assisted by a GP specialist advisor.

Background to Dr Vasanth and Partners

Dr Vasanth and Partners practice is based at Atherton Health Centre, Atherton, Manchester, M46 0LE and is within Wigan Borough CCG area.

The practice delivers commissioned services under the General Medical Services (GMS) contract with one full time male GP and one part time female GP, a practice manager and four administrative staff.

The practice had a list size of 2464 patients at the time of our inspection. The level of deprivation in the practice catchment area is higher than the England average. The provider has one location:

The practice shares a purpose-built building with a number of other NHS and local authority service providers, including two other GP practices. There is an in-house pharmacy and a sexual health service, which provides rapid access to GP patients. The pharmacy is open seven days a week. The building is fully wheelchair accessible and is designated as 'breastfeeding-friendly'. The practice has a counselling room, which can be used for patients with mental health illnesses or high levels of anxiety who need a low-stimulation environment.

The practice has a range of different opening hours, which have been established to meet the changing needs of the local population. Routine appointments are available

between 9am – 5.30pm on Mondays; 9am – 5.30pm on Tuesdays; 7.30am – 11am on Wednesdays; 9am – 5.30pm on Thursdays and 7.30am – 5.30pm on Fridays. Three telephone consultation appointments are available daily and four GP home visit appointments are available per day, Monday – Friday. The practice nurse offers two home visit appointments one day per week. The lead GP offers ad-hoc 'pre-opening' slots each week between 6am and 7am.

The practice has arrangements in place for patients who need appointments out of hours. On Wednesdays from 1pm to 6.30pm, a local GP practice provided call handling, telephone appointments, a face to face service and urgent home visits. At times when the service was closed, patients were directed to out of hours or NHS 111 services.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on March 24 2016.

During our visit we:

Detailed findings

- Spoke with a range of staff including GPs, the practice nurse and three administration staff. We spoke with patients who used the service.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- The practice manager and healthcare assistant were unavailable during the 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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

Are services safe?

Our findings

Safe track record and learning

- The practice reported three significant events (SEs) in the 12 months prior to our inspection. An SE is an incident that impacts the service, its staff or patients and is normally subject to a significant event analysis in line with Royal College of General Practitioners guidance
- The minutes of significant event analysis meetings indicated appropriate root cause analyses and learning had taken place to identify changes in practice. For example, the practice identified a need for more proactive and responsive communication with the district nurse when a patient was discharged from hospital on a palliative care package.
- There was an incident reporting policy and a no blame policy in place, which staff were aware of and told us they felt confident to use. This formed part of an open incident-reporting culture, where staff felt learning from incidents meant practice was improved and safety risks reduced.
- Staff demonstrated thorough approach to investigations carried out following a significant event. For example, the lead GP sought advice from the local authority and from a medicolegal organisation on the authorisation of a do not resuscitate (DNR) after the relative of a patient made a complaint. The practice response demonstrated compassion for the relative and ensured the patient was the main consideration during the investigation.
- The practice nurse monitored any children who did not attend for planned immunisation appointments. They liaised with the health visitor regarding this and proactively contacted parents to ensure the child received appropriate immunisations.
- The practice adhered to the GP safeguarding assurance toolkit issued by the CCG, which included the appointment of a safeguarding lead and a safeguarding deputy.
- The child safeguarding lead or deputy met with the link health visitor on a monthly basis to discuss vulnerable children and families and to identify children in need and children at risk. This included children with complex needs that clinical staff identified as indicative of heightened risk.
- All staff had received safeguarding training appropriate to their role. Reception staff were trained to respond appropriately to requests from social services for child at risk reports, which were prioritised for immediate referral to a GP.
- Staff understood the whistleblowing policy, which was in line with the principles of the Public Interest Disclosure Act 1998.
- An up to date chaperone policy was in place, which adhered to the principles implemented by the NHS National Clinical Governance Support Team. The policy was available in the waiting room, through the practice website and in the patient information leaflet. Staff who could act as a chaperone had received appropriate training using national best practice guidance and had a certificate from the Disclosure Barring Service.

Overview of safety systems and processes

There was a child safeguarding policy in place, which followed best practice guidance of the General Medical Council and had been reviewed on an annual basis. The policy included scenarios for staff to help them decide when a safeguarding referral should be made. The practice also had an at-risk adults policy, which provided safeguarding information for staff. This policy was updated on an annual basis.

- All of the staff we spoke with were aware of the child safeguarding policy and could tell us how they would put it into practice. Staff had made safeguarding referrals to the local authority appropriately using the policy.
- Medicine stocks were checked and documented monthly by the practice nurse.
- Patients were offered repeat prescriptions only when the GP was satisfied this would be in their best interest in line with the practice repeat prescription and medication review policy. A GP conducted a medication review with each patient on long-term repeat prescriptions on an annual basis. This review took place twice yearly for patients over the age of 75 who were prescribed four or more medications. One-to-one discussions with the patient formed part of annual medication reviews, which took place with pharmacy support.

Are services safe?

- Clinical staff worked with a medicines management technician to conduct audits and support with an annual peer review. The technician also supported staff in a script switch project, which looked at reducing the cost of medicines.
- The practice nurse updated patient group directives for childhood vaccinations and travel immunisations. A patient group directive is a written instruction for the supply and administration of medicine to groups of patients who may not be identified individually before they present for treatment. The practice adhered to national best practice.
- The lead GP partner and practice nurse monitored drug alerts from the Medicines and Healthcare Products Regulatory Agency, which were audited for compliance. When an alert was received, the practice nurse reviewed patient records and made arrangements for anyone affected.
- GPs adhered to an effective safety prescribing protocol for high-risk medication. For example, warfarin would only be prescribed if the GP had access to the patient's international normalised ratio (INR) information to make sure their blood clot rate meant it was safe for them to take this medicine.
- Patients over the age of 75 who were prescribed four or more medications on a repeat basis were given a medication review every six months to ensure their prescription remained appropriate and safe.
- Cleaning in the practice was managed and audited by a contractor who was responsible for the whole building. The practice maintained an up to date policy on the control of substances hazardous to health (COSHH). The practice manager completed an audit of COSHH processes and found some staff were unaware of the regulations. Training had been arranged to correct this.
- The cleaning contractor completed a monthly audit of cleaning and infection control in the practice. This included high-level and low-level surfaces and individual items such as fire extinguishers and ventilation ducts. We looked at the audit results for the 12 months prior to our inspection and found audit results to be 100% in all months except two, where they were 99%.
- Carpets and curtains were disinfected and cleaned every three months.
- The practice adhered to legionella testing guidance and the practice manager performed periodic risk assessments and hazard investigation for the practice water supply.
- The practice manager had undertaken a comprehensive internal infection control audit and inspection in all areas of the practice. This inspection found good practice in most areas in relation to infection control principles. Where areas for improvement were identified, the practice manager implemented an action plan.
- Antibacterial hand gel was available in all clinical areas and handwashing areas had posted instructions on the correct technique to use. A recent audit had resulted in the updating of this guidance.
- The practice manager used a new employee recruitment, selection, interview and appointment policy and protocol to ensure new staff were recruited according to their competence and ability. Staff used the policy to ensure they adhered to the requirements of the Equality Act 2010 and applicants were considered free from discrimination. Employment records indicated this policy was used in practice.
- New staff completed a supervised induction programme before working alone. This included initial health and safety training and identification of training requirements specific to the job role. The induction programme had been updated at appropriate intervals to reflect changes in the practice and was overseen by the practice manager, who could assign additional supervised hours if new staff needed a longer period of support.
- Staff were supported to receive appropriate vaccinations and the practice manager maintained a record of this.
- All staff had an up to date certificate from the Disclosure Barring Service and had been recruited following appropriate checks.
- **Monitoring risks to patients**

There were procedures in place for monitoring and managing risks to patients and staff safety.

- The practice had an up to date health and safety policy, which was used in staff training to ensure working practices reduced the risk of harm to staff, patients and visitors.

Are services safe?

- The practice had a formal statement on physical restraint policy in place, which adhered to the CCG's Mental Capacity Act Code of Practice.
- Fire safety was managed by an external contractor on behalf of the premises management company. In addition to this the practice had a fire safety risk assessment, which identified action for staff to take in the event of an evacuation where a colleague, patients or visitors had reduced mobility. The policy was up to date and comprehensive.
- We looked at fire safety logs for the 12 months prior to our inspection. The practice manager had undertaken fire marshal training in the previous six months. Fire extinguishers had documented checks every month and fire alarms and emergency lights were tested every week. The last practice evacuation had been in September 2013 and the fire safety contractor had found a number of areas for improvement in the practice. The practice manager had updated training as a result.
- A fire safety inspection report in July 2015 required the practice to fit an internal door with a self-closing device connected to the fire alarm system. Such devices are used to contain a fire in a small area to protect people and property. We saw the door had not been fitted with the device and talked with the practice manager about it. The maintenance of the building, including modifications, was the responsibility of the building management company. This issue had been escalated to them but they had not acted. The practice manager contacted them again after our inspection.
- An unannounced fire drill for the whole building took place quarterly and practice staff were assessed for their response to this.
- Reception staff used an emergency telephone call handling protocol to establish the medical urgency of patients using three priority classifications. Staff had been trained in the use of this protocol and it was readily available next to each telephone used to accept calls from patients.
- Reception staff had access to an urgent response pathway for people in reception who presented with chest pains. This ensured patients who needed urgent or emergency care could access this rapidly.
- An established protocol was in place for the handling of patient emergencies in the reception area, which ensured staff would obtain emergency support from a GP or the practice nurse while providing immediate help to the patient in distress.
- Medical equipment was tested and calibrated by a specialist contractor at the frequency recommended by each manufacturer.
- Electrical equipment in the practice had been certified as safe following portable appliance testing (PAT) in January 2016.
- The practice nurse checked stock of specific equipment after each clinic, such as speculums after a baby clinic. This meant the practice had a system in place to ensure a minimum stock of essential equipment was maintained by a responsible person.

Arrangements to deal with emergencies and major incidents

- An emergency incident procedure was in place to provide staff with guidance when dealing with unpredictable, aggressive or violent behaviour. Consulting rooms were fitted with panic alarms, which would alert reception staff and the behaviour policy was displayed at reception. The practice was situated in a building occupied by a number of other health services and staff considered their safety to be protected due to the number of other staff in the building who could easily be summoned.
- The lead GP sometimes offered ad-hoc appointments in the early morning or evening, when the practice had no other staff in the building. There was no risk assessment in place or an established plan to ensure their safety during lone working.
- Resuscitation equipment was available, which included an automatic defibrillator and oxygen. Staff completed and documented monthly checks on the equipment and were trained in the use of the automatic defibrillator to Resuscitation Council UK guidelines. All staff in the practice had basic life support training, including cardiopulmonary resuscitation.
- Emergency medicines were easily accessible
- The practice had a comprehensive business continuity plan.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records..
- Staff used a risk calculator to assess the needs of patients whose circumstances made them at high risk of an unplanned hospital attendance. These patients were allocated to a community matron or community nurse, who worked with the practice to reduce attendance at emergency departments. The practice nurse supplied antibiotic and steroid rescue packs to patients for use in an emergency and to try and prevent a hospital admission.
- The practice nurse provided a cytology service and followed up on colposcopy referrals to encourage patients to attend for their results. They also provided specialist support for patients with Crohn's disease and encouraged patients to attend their follow-up appointments for blood test results.
- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 93% of the total number of points available, with 11% overall exception reporting. The practice reported a higher than 10% difference with the national average in exception reporting for three clinical domains: osteoporosis, stroke and transient ischaemic

heart attack and atrial fibrillation. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effect).

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 similar to the national average. The practice performed better than the national average in the number of patients with diabetes who had a flu vaccine, at 99%.
- Performance for mental health related indicators was similar to the national average overall and better than the national average in the recording of alcohol consumption and the preparation of care plans.

There was evidence of quality improvement including clinical audit.

- There had been eight clinical audits completed in the last two years, seven of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included an open appointment system to reduce waiting times

Information about patients' outcomes was used to make improvements such as:

- The lead GP had completed a three cycle audit of treatment and testing standards set by the British National Formulary in the prescribing of disease-modifying antirheumatic drugs (DMARDs). The audit indicated 100% compliance.
- The lead GP had conducted an osteoporosis audit to check all patients who were required to take bone prophylaxis received this. The audit used NICE guidance and terms of reference from a local osteoporosis guideline group to benchmark its criteria.
- The practice used direct access hospital services including electrocardiograms, electrocardiography and echo. This reduced the number of referrals and improved the range of care available to patients. This had a demonstrable impact on patient outcomes. For example, one patient in cardiac failure was managed

Are services effective?

(for example, treatment is effective)

in-house using outpatient investigations without the need for a hospital admission. Clinical staff also managed a patient with chronic renal failure, which meant they did not need to be admitted to hospital.

Effective staffing

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

- Clinical supervision formed a part of the practice clinical governance framework and the practice manager and lead GP actively used this to maintain and improve standards of care and treatment. Routine clinical supervision records were maintained for observed skills in phlebotomy and blood pressure.
- Non-clinical staff received regular one-to-one supervision to identify areas of good performance and discuss areas for improvement.
- The practice nurse attended annual immunisation update training to ensure their practice met the most recent national guidance. This member of staff had specialist training in line with their clinical responsibilities and specialist clinics. This included training in basic life support and anaphylaxis, cervical smear samples, safeguarding and child abuse, and acting as a chaperone.
- Staff who completed smear tests were subject to an annual audit of their practice. From April 2014 to March 2016, clinical staff performed 252 smear tests. The audit found all of the tests to be adequate.
- The practice nurse attended the area practice nurse forum each month, which was an opportunity to share new knowledge and best practice for GP surgeries with colleagues also familiar with the local population.
- GPs and the practice manager were supportive of staff who wanted to take extra training. For example, the lead GP had supported the practice nurse to undertake a specialist course on diabetic care and care of patients with COPD. Some administration staff wanted to undertake training to enable them to summarise patient notes and the practice manager had begun to provide this.
- The practice manager ensured staff were up to date with annual mandatory training updates and staff had access to protected time for training on a weekly basis.

- All staff received an annual appraisal. We saw appraisals were used to identify areas for new learning and training.
- An information pack was available for locum GPs. This had not been updated for some time and did not contain adequate information for temporary doctors. We spoke with the lead GP about this who agreed and said they would update the pack immediately.
- Staff had undertaken additional clinical training to meet the needs of the local population and in line with their professional interests. This included specific courses such as: optimal treatment for patients with diabetes, medical problems in pregnancy, clinical pathways covering General Medical Council domains, psoriasis, chronic heart failure, diagnosis and management of vertigo, dementia early intervention, acute asthma, and pelvic pain.

Coordinating patient care and information sharing.

- Practice staff had established links with a range of professionals to ensure people's needs were met and risks of harm minimised, including community link and support workers, social workers, alcohol and drugs liaison staff, community matrons, palliative care nurses, a tissue viability nurse, the in-house sexual health service and health visitors
- The lead GP facilitated a monthly multidisciplinary team meeting attended by a district nurse and other community health professionals relating to current patient care and treatment. The practice nurse did not routinely attend this but was updated on specific patients at clinical practice meetings.
- As part of the directed enhanced services to reduce unplanned hospital admissions, clinical staff followed up hospital discharge letters with patients and liaised with hospital specialists to identify strategies to reduce the future risk of admission. Clinical staff discussed hospital admissions at two-weekly practice meetings, which included identification of strategies they could use to prevent future admissions. Staff used this process to follow up on concerns raised by hospital staff, such as when they had spoken with the GP with regards to a patient's personal hygiene. Practice staff were proactive in following this up with social services.
- Where a patient had been admitted to hospital, the practice nurse liaised with hospital staff to assess the reason for the admission. This member of staff visited the patient if necessary.

Are services effective?

(for example, treatment is effective)

- The lead GP and practice manager met with the health visitor monthly. The meetings were used primarily to discuss children at risk and of abuse or neglect. We saw from the minutes of meetings that the circumstances of at-risk or in-need children were discussed in their best interests and the GP and health visitor worked closely together to ensure the parents of children at risk were supported appropriately. A communication book was held at reception for the health visitor to check on each visit as an additional measure to ensure vulnerable children were monitored regularly.
- The practice nurse established a relationship with a tissue viability nurse and the district nurse to offer patients additional consultation support in the practice and by phone.
- Clinical staff worked closely with local adult social care providers, such as care homes, to implement advanced care planning and care pathways for people with dementia and mental health needs.
- Clinical staff worked proactively with other services to meet the care needs of patients with terminal conditions. This formed part of a patient-centred approach that ensured patients understood their treatment options and were supported to make an informed decision

Consent to care and treatment

- A consent policy was in place and had been recently updated by the practice manager. Staff adhered to the policy in practice.
- GPs were able to complete mental capacity assessments using the principles of the Mental Capacity Act (2005).
- We saw from looking at mental capacity assessments these were conducted to enable the person to retain as much independence as possible and to help them understand the outcomes of assessments.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and drug use. Patients were signposted to the relevant service, including to a local gym for help with weight management.

- A sexual health service was available on-site and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 77%, which was comparable to the CCG average of 82% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 71% to 96% and five year olds from 87% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

- The practice monitored the uptake of seasonal flu vaccines against other practices in the CCG. In the most recent audit available, for January 2015, the practice did not meet the 75% uptake target for any of the three patient groups targeted. The practice achieved an average of 57%. This had been discussed at a peer review group meeting and clinical staff actively engaged with other practices to improve uptake for the next seasonal flu vaccine.
- A GP had undertaken training in health promotion areas including promoting physical activity, food allergies in children and preventing emergency hospital attendances in patients with mental health issues.

Are services caring?

Our findings

Kindness, dignity, respect and compassion.

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

Curtains were provided in consulting rooms to maintain patients privacy and dignity during examinations

Consultation and treatment room doors were closed during consultations and treatments and conversations could not be overheard.

Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The latest available GP Patient Survey data was published in January 2016. In this survey 16% of patients were invited to participate and the response rate was 26%, with an overall positive experience recorded by 97% of people.

- 97% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 96% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.
- We asked five patients about their experiences at the practice and they provided positive feedback regarding the practice.
- People told us practice staff paid attention to detail in offering a personal service. For example, one person said they appreciated the GP or nurse coming into the waiting room to collect them rather than using the automated announcement system.

- Respect and dignity formed a core element of the practice charter and the code of conduct for staff.

Care planning and involvement in decisions about care and treatment

- We talked with patients about their involvement in their own care and treatment. In all cases people told us clinical staff had taken the time to explain their treatment options and care plans to them.

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:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 92% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.
- The practice provided structured support to the carers of patients with long-term conditions. This included signposting carers to specialist support agencies, liaising with social services to provide respite care and offering health checks for the carers. Staff also offered carers health promotion such as the flu vaccine.
- Clinical staff explained long-term conditions and treatment options, including benefits and risks of medicines, to patients clearly to help them make informed choices.
- The lead GP had met with a trainer for the Diabetes Education and Self-Management for Ongoing and Diagnosed (DESMOND) education course, which enabled them to involve patients with diabetes in their own care planning.
- Clinical staff provided one-to-one instruction for patients who used an inhaler to help them improve their technique.
- The main patient waiting area contained printed information for patients on a range of conditions and support services, including dementia, sexual health, arthritis, an alcohol liaison team, community link workers and an autism carers support group.

Are services caring?

Information on an innovative smartphone application that could be downloaded and use to help support someone who wanted to stop smoking was also available.

Patient/carers support to cope emotionally with care and treatment

- Patients had access to an in-house counselling service, to which GPs and the practice nurse could provide referrals.
- The practice offered end of life care and bereavement and emotional support to patients and their relatives.

This included regular home visits by a GP and a meeting with relatives after a bereavement to offer signposting to support services or to help their understanding of medical documentation, such as a coroner's report.

- People told us practice staff were proactive at reminding them about appointments, particularly when their circumstances meant they could forget. For example, staff knew one person had recently been bereaved and made sure they kept in touch to remind them about their own health appointments in the following weeks.

Patients we spoke with told us because the practice was family-run, they felt involved and supported by staff because they had known them for a long time.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice had an active patient participation group (PPG) made up of seven patients who met on a quarterly basis with the lead GP and practice manager. The PPG had met to discuss the latest GP Patient Survey data and to discuss areas for improvement. For example, the lead GP and practice manager had begun to discuss the possibility of improving the telephone system by introducing a telephone queuing system. This was discussed with the PPG, whose members stated they preferred to call back rather than wait as a telephone waiting system would be impersonal.
- Clinical staff demonstrated an evidence-based understanding of their local population based on age, background and ethnicity. For example, staff understood that health risks existed in specific population groups and targeted these for health checks and tests during routine appointments. This demonstrated an individualised approach to ensuring people's needs were met, such as people whose heritage meant they were at heightened risk of diabetes or heart disease and people from countries where alcohol use and smoking were known to be comparatively high.
- Where a patient was unlikely to attend scheduled appointments due to their health condition or social factors that made them vulnerable, clinical staff offered opportunistic appointments so that their needs would still be met as far as possible. For example, where a patient had needs relating to drug dependency, they were able to see a GP at short, opportunistic notice so the GP could monitor their health and provide support in line with guidance from the alcohol and drugs team and the person's community worker. This approach to flexible appointments meant people with the highest need for support could be seen without delay.
- The practice nurse conducted new patient medical reviews, including health checks for those over 75 years old and new born babies.
- The lead GP conducted follow up reviews for patients after a discharge from hospital, which could be completed through a home visit if needed.
- Care plans were prepared and used to ensure individual needs were met, including for patients with dementia, a mental health illness and long term conditions. These included information relating to safeguarding when clinical staff considered a patient to be at risk.
- Clinical staff arranged for subcutaneous fluids and syringe drivers to be provided at home for patients who needed end of life care. Staff also had established links with palliative care nurses who provided patients with at-home support.
- District nurses, a phlebotomy service and a sexual health clinic shared the practice building. The practice had developed a relationship with the sexual health clinic, which was able to accept patients with an open referral from their GP.
- Printed home care information was available for patients at reception. This included information to help people understand their condition, such as ear infections, sore throats and the common cold.
- The lead GP had produced a comprehensive and easy-to-understand information document designed to help people choose the most appropriate NHS service for their needs. This included details of the services the pharmacy could provide as well as direct contact details for 17 specific services such as female sexual health, child podiatry, anger management and alcohol or drug problems. This resource was designed to help people make an informed decision about where to get the fastest help and to discourage the inappropriate use of GP appointments for the hospital emergency department.
- People told us they appreciated the speciality care offered by the practice nurse, particularly specific clinics such as for diabetic care.
- Staff in the practice had an exceptional understanding of the barriers to equitable healthcare their local population faced, along with an acute understanding of changes in the local population. The practice adapted their approach to care to meet the changes.
- All staff had undertaken equality and diversity training and worked to a related policy. The policy included a zero tolerance approach to discrimination, which included during the recruitment and selection of new staff.

Are services responsive to people's needs?

(for example, to feedback?)

- The design and facilities of the practice building demonstrated the promotion of equitable access to services. The GP reception desk included a hearing loop, there were dedicated disabled parking bays available and the building was a designated a 'breastfeeding-friendly' space. Toilets in the building included posters with the contact details for a local provider for the support of people who experienced domestic violence.
- Large print guidance was available to patients to explain certain procedures, such as blood tests.

Access to the service

- The practice had a range of different opening hours, which had been established in consultation with the patient participation group and to meet the changing needs of the local population. Appointments were available between 9am – 5.30pm on Mondays, Tuesdays and Thursdays, 7.30pm – 11am on Wednesdays; and 7.30am – 5.30pm on Fridays. Three telephone consultation appointments were available daily and four GP home visit appointments were available per day, Monday – Friday and the practice nurse offered two home visit appointments one day per week.
- The lead GP offered ad-hoc 'pre-opening' slots each week between 6am and 7am depending on patient need.
- Where a bank holiday meant the practice would be closed on a Friday or Monday, the lead GP offered a number of Saturday morning appointments to ensure continuity of care for patients with high levels of need.
- To supplement the GP Practice Survey with more detail, the practice had undertaken its own opening hours survey. Patients indicated they would find early morning appointment slots more valuable than weekend opening hours. To address this, two early morning GP surgeries and an early morning nurse surgery had been implemented each week.
- A new urgent appointment triage system had been implemented whereby reception staff would relay appointment requests to the GPs on duty and then call the patient back with appointment information. This took place following patient feedback on the previous system whereby reception staff were responsible for triaging calls without specific medical training.
- The practice nurse offered appointments between 9.15am – 5.50pm on Tuesdays; 7.30am – 11.55am on Wednesdays and 9.15am – 6.20pm on Thursdays.

- Improved access times and an increase in the number of nurse-led appointments available, as well as a proactive approach by the practice nurse to contacting patients, had increased cervical smear uptake.
- A health trainer was available in the practice on a Friday between 9.15am and 12.15pm. This service was provided to support people with health promotion and lifestyle management needs, such as in weight loss, sexual health and smoking cessation.

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

- 82% of patients said they generally found it easy to reach the practice by phone compared with the CCG average of 77% and national average of 73%
- 84% of patients said they were very satisfied or fairly satisfied with the practice opening hours compared with CCG average of 83% and national average of 79%

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

Listening and learning from concerns and complaints

- The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.
- In 2015/16, the practice received three formal written complaints. We looked at the investigations of the complaints and of the actions taken to resolve them. In each case staff had explored opportunities for learning and service development and implemented changes where appropriate. For example, one patient described a poor experience during a referral to a specialist health service. To simplify this process for future referrals, administrative staff were able to provide support to patients in completing paperwork during quiet periods.
- The practice complaints policy was available in the patient information guide, was readily available in the waiting area and on the practice website. A guide to the NHS Complaints Procedure was made available by the CCG in the waiting area.

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 current statement of purpose in place, which clearly outlined the scope and regulated activities of the practice.
- An established vision was in place in the practice, which placed patient-centred care as its focal point and ensuring they were involved in decision-making about their care and treatment. This vision was very much part of the working culture of the practice, where staff worked openly and honestly with each other and with patients so that information sharing led to effective decisions.
- Staff were encouraged to suggest and trial small changes to the service as part of the long-term strategy to ensure patient-centred care was delivered consistently. Such trials were discussed openly with members of the PPG, who provided critical feedback during quarterly meetings.

Governance arrangements

- The practice had a clinical governance policy that was up to date and established areas of clinical audits, continuing professional development for staff and health and safety risk control. We saw this policy was used to guide decision-making in practice meetings and meetings with the CCG.
- Practice meetings were held and minuted at least monthly. The meetings were attended by all practice staff and were used to discuss the outcomes of significant events, targets relating to the QOF and working with other services.
- All staff had up to date information governance training and were able to tell us how this was adhered to in practice.
- The practice manager and lead GP met with the CCG monthly. As part of this relationship, the locality support officer provided ad-hoc training to practice staff, particularly in relation to patients at high-risk of unplanned hospital admission.
- The lead GP attended a monthly GP forum, which enabled them to engage with other doctors for educational, clinical and organisational purposes

Leadership, openness and transparency

- All of the staff we spoke with described a pleasant place to work with a supportive practice manager and lead GP. The practice manager proactively considered ways of providing staff with a work environment they could feel comfortable and challenged in to promote their professional development. Senior staff demonstrated an acute awareness of the risks associated with running a family practice whereby some members of staff were related. The practice manager mitigated such risks by fostering a working atmosphere that valued each person's contribution and ensuring they felt valued on a daily basis.
- We asked staff about leadership in the practice and were told in all cases morale was high and staff enjoyed working there.

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

- Staff told us they felt listened to and that their feedback was considered and acted upon. They could provide feedback to the leadership team during practice meetings or by speaking to or e-mailing the practice manager.
- One member of staff told us patients who were abusive or attended under the influence of alcohol presented a challenge. It was not clear how this had been acted upon as staff did not formally receive de-escalation or conflict resolution training.
- Practice staff actively engaged with patients through the PPG, responding to individual feedback and the practice satisfaction survey. Staff reported an increase in patient satisfaction when they had begun to share decision-making with them, which meant patients were better informed and felt empowered in their care. For example, GPs had discussed treatment options with a patient with a terminal condition and worked with them to focus on improving their quality of life rather than beginning invasive or restrictive treatment.
- The PPG were involved in planning for trials and pilots and their input was considered. For example, the lead GP consulted the group following an audit on waiting times showed a significant number of patients waited in excess of 30 minutes from their booked time. In consultation, a trial period of 'open' appointments was decided upon and the outcome of this approach was scheduled to be discussed after it had been in place for three months.

Are services well-led?

Good 

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

Continuous improvement

- Senior staff had engaged with the CCG to complete a quality peer review. This involved a self-directed practice development plan, which would then be assessed by peers. Areas the practice had selected for scrutiny and improvement were the development of

their own safeguarding toolkit, a review of all patients with asthma and liaison with the breathlessness service and a review of people with chronic obstructive pulmonary disorder.

- The practice manager used a continuous quality improvement systems policy to ensure the practice met the needs of its population and the CCG through a process of continual quality checks.