Dr Shivraj Chudha

Quality Report

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Date of inspection visit: 29 April 2015
Date of publication: 06/08/2015

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 Shivraj Chudha (also known as Blackfriars Medical Practice) on 29 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for the six population groups we report on: 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 and People experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed
- 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.
- Information about services and how to complain was available and easy to understand.
- 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 facilities and was well equipped to treat patients and meet their needs.
- 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.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

Summary of findings

ensure that relevant health and safety assessments are completed in the recommended timeframe or make provision for alternative assessments to be completed

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. 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. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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 facilities and was well equipped to treat patients and meet their

Summary of findings

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?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activities which were kept under review. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP.

The practice had been participating in the Southwark and Lambeth Integrated Care (SLIC) programme in 2014-15. This programme included the implementation of the Holistic Health Assessment (HHA) for those identified to be at need. The HHA encompassed a wide range of assessments including fracture risk, blood pressure monitoring, nutrition, falls risk, Dementia screening, pain and self-care. The practice carried out 50 HHAs in the surgery during the year ending 31 March 2015, which was above their target of 38. A further five HHAs were conducted via home visits.

For the year ending 31 March 2014, the practice achieved a seasonal flu vaccination rate of 76% among its patients over the age of 65.

The practice has also participated in the Admissions Avoidance Scheme in 2014-15, and had a register of 125 patients being actively monitored as part of the scheme.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice participated in the Admissions Avoidance Scheme in 2014-15.

Longer appointments and home visits were available when needed. All their patients with chronic long term conditions had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

The practice has consistently achieved very high Quality and Outcomes framework (QoF) scores. As at 31st March 2015 the practice achieved 403 out of a possible 432 points in the clinical indicators. For the year ending 31 March 2014, they achieved an overall QOF score of 96.1%.

During 2014, the practice employed a Health Care Assistant to support the clinical staff in the delivery of certain aspects of QoF, as well as assisting with the recall processes.

In line with their local federation targets, the practice had improved its diagnosis and detection of long term conditions and therefore increased their disease prevalence for COPD, Diabetes and Hypertension.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

The practice's performance for childhood immunisations for 2013/14 was relatively high compared to other practices in the local area for most immunisations recommended at 12 months, 24 months and at five years of age. The practice had systems in place for invitation and recall of patients when they were due recommended vaccinations. This included birthday card / reminders to five year olds.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice hosted a weekly baby clinic on Wednesday afternoons, which was only available to registered patients in the area. We saw good examples of joint working between the practice team and midwives and health visitors.

The practice had staggered start times for their GPs so that appointments were available throughout the morning up until 12:30pm.

The practice participated in a local enhanced service for sexual health which was mainly focused on chlamydia screening.

Working age people (including those recently retired and students)

Good

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

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this population group.

The practice offered extended hours clinics with doctor and nurse on Tuesdays from 6:30-8:00pm.

Southwark CCG was a recipient of the Prime Minister's Challenge Fund and had set up an Extended Primary Care Services centre. This offered access to GP appointments from 8am-8pm, 7 days a week at the Bermondsey Spa Medical Centre, should the practice be unable to accommodate access to a doctor's appointment. The practice team told us that there were plans for a nursing service to also be made available in the near future.

The practice offered telephone consultations, online access to appointments, prescriptions and aspects of the medical record. The practice piloted Electronic prescriptions for Southwark PCT a few years ago and they offer online appointments, prescription requests and access to aspects of medical record.

The practice offered phlebotomy services on site via the practice nurse from 8am.

The practice offered NHS Health Checks, and in the year ending 31 March 2015 they completed 344 checks, which was 203 more than the target set by our local GP federation.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

The practice participated in the Learning Disabilities Directed Enhanced Service.

The practice had participated in a scheme with Southwark CCG to enhance access to information for Carers. The practice hosted a representative from Southwark Carers on the first Monday morning of each month wherein patients can have an appointment or drop in to learn about the support they can receive, including but not limited to benefits advice and respite care advice.

Clinical staff completed annual safeguarding adults and children training usually facilitated by the CCG as a protected learning time event. Those who were unable to attend the CCG organised event completed the course online via e-Learning.

The practice participated in the Alcohol screening DES for the last few years and in the 2014-15 year screened 1446 new patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). For the 2013 / 14 year, 82% of people experiencing poor mental health had a comprehensive care plan documented in their record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice participated in a Southwark-wide initiative to screen more patients at risk of dementia in 2014-15. The practice screened 135 patients at risk of dementia in the year ending 31 March 2015. This was based upon a register of at-risk patients via their clinical records system and also those highlighted by searches produced via the CCG. The practice team reported that they had seen increased awareness about dementia among family members and carers as a result of their dementia screening programme.

Benchmarking data from the local CCG area showed that the practice was performing better than its peer average in its referral rates of patients with mental health needs to the Improving Access

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to Psychological Therapies (IAPT) service. For October to December 2014, the practice had a referral rate to the IAPT service of 21.45 per 1000 of their weighted list, whilst their peer average was 16.22 per 1000 of their weighted list.

The practice achieved 22.37 out of a possible 26 QoF points for Mental Health. The practice participated in the Dementia Direct Enhanced Service (DES) in 2014-15 and planned to continue to do so in 2015-16.

Summary of findings

What people who use the service say

We looked at the results of the national GP patient survey published on 08 January 2015. This contained aggregated data collected from January to March 2014 and July to September 2014. For Dr Shivraj Chudha, there were 451 survey forms distributed and 99 forms were returned. This is a response rate of 22%

We received 27 CQC comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. Most of the comments cards were entirely positive, with patients saying they received a consistently good service, felt satisfied with the care they received, and that the staff team kept a good attitude, and were helpful and attentive to their needs. Three of the comments cards also included less positive comments but there was no theme to these.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Data from the national GP patient survey aligned with these views and showed that the practice performed particularly well against the local area and national averages for most aspects of care.

Areas for improvement

Action the service SHOULD take to improve

Ensure that relevant health and safety assessments are completed in the recommended timeframe or make provision for alternative assessments to be completed

Dr Shivraj Chudha

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The other member of the team was a GP specialist advisor. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Shivraj Chudha

Dr Shivraj Chudha (also known as Blackfriars Medical Practice) is located in the northern side of the London borough of Southwark, close to the south side of Blackfriars bridge.

At the time of our inspection the practice had approximately 7000 registered patients.

The practice clinical team led by the most senior GP in the practice, Dr Shivraj Chudha, are five GPs, two practice nurses and a healthcare assistant. They were supported by a practice management team that comprised of a practice manager, a part time business manager, and a team of administrative and reception staff.

Blackfriars Medical Practice has a personal medical services (PMS) contract for the provision of its general practice services. Services provided in the practice include general medical services, mother and baby clinic, contraceptive services, minor surgery, counselling, phlebotomy, and travel health.

Blackfriars Medical Practice is registered with the Care Quality Commission (CQC) to carry on the regulated activities of Diagnostic and screening procedures; Treatment of disease, disorder or injury; Maternity and midwifery services; Family planning; and Surgical procedures to everyone in the population. These regulated activities are provided from the practice site at 45 Colombo Street, London SE1 8EE.

The practice is open between 8:00am and 6:30pm on Mondays, Wednesdays, Thursdays and Fridays; and between 8:00am and 8:00pm on Tuesdays. Doctor appointment times are between 9am-12:30pm in the morning and 4pm – 6:30pm in the evening. Nurse appointment times are available from 8am on Mondays to Thursdays. On Tuesdays the practice operates extended hours so that the surgery offers appointments from 8am and is open until 8pm.

The practice had opted out of providing out-of-hours services to their patients, and had contracted an external provider to provide out of hours services.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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.

This provider had not been inspected before and that was why we included them.

Detailed findings

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.

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 April 2015.

During our visit we spoke with a range of staff (GPs, nursing staff, practice management, reception and admin staff) and spoke with patients who used the service.

We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety, including reported incidents, national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example following an incident where a sample was sent off for analysis with unclear hand written details on the label and the results were returned and attached to the wrong patient's record, the practice had moved to using their electronic pathology system that included pre-printed sample labels.

We reviewed safety records, incident reports and minutes of meetings where these were discussed over the 12 months preceding our inspection. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the last year and saw this system was followed appropriately. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked an incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example a new protocol for checking immunisation records prior to administering a new vaccination was agreed during a practice meeting, following an incident where a patient was provided a flu vaccination when they had already received one a few weeks prior. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager and the business manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings or clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. However some of the GPs and the practice nurse were due to have update training sessions in child protection. The business manager told us they were aware of this, and that sessions were being scheduled for May 2015.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a GP as the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The safeguarding lead GP and the practice's healthcare assistant had recently attended training provided by the CCG in adult safeguarding and the mental capacity act. E-learning courses in adult safeguarding and child protection were available for all staff.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients

attended appointments; for example children subject to child protection plans. There was active engagement from the practice in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including the health care assistant, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the local authority and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential power failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had a repeat prescribing protocol, and a designated prescribing lead. Specific administrative staff in the practice had received training in issuing repeat prescriptions and they were the only non clinical staff who issued them.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the lead GP. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

Good

Are services safe?

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits; including of hand hygiene practices and of the premises and equipment, and that any improvements identified for action were completed on time.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out two yearly risk assessments for legionella and that the last assessment was completed in June 2013.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed calibration and maintenance tests had been completed in October 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice had contracted an external company to carry out health and safety audits in the past, with the most recent audit having been completed in November 2013. They had also had an asbestos survey completed in February 2014.

In the past the practice had contracted external companies to carry out disability discrimination act assessments and fire risk assessments on their premises and operational arrangements. The last assessments completed had been

stated by the contractors as being due for re-assessment in 2013. However, the practice had not undertaken any further assessments in these areas since that time. and had made no alternative arrangements for these assessments to be completed or reviewed to determine if they were still required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies.

Records showed that all staff had received training in basic life support. We found that the basic life support course had been completed in February 2012, and was due to be renewed in February 2015. The practice management showed us evidence that they had booked a session for the practice team for 13 May 2015.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice contracted an external company to carry out twice yearly fire systems checks and maintenance. The last check was carried out in March 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

Blackfriars Medical Practice offered minor surgery injections and aspirations in line with the minor surgery directed enhanced services (DES), which they were authorised to provide by NHS England.

The practice offered osteopathy in house and practice based counselling via Improving Access to Psychological Therapies (IAPT). The practice staff told us that these services were much valued by their patients. The osteopathy service was available for other practices to refer their patients to.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their health outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and an administrator to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year. The first was a methotrexate audit, initiated following an incident where a patient on warfarin was not being properly monitored. The first cycle of the audit was undertaken between April and May 2014, and found that all eligible patients that met the audit criteria were being appropriately monitored. A second cycle was due to be repeated in May 2015.

The second audit was of repeat prescribing, and was a local CCG prioritised audit. The aim was to improve the quality of repeat prescribing policies and systems in the local practices. The first cycle of the audit completed in March 2015, confirmed that the practice is adhering to its Repeat

Good

Are services effective?

(for example, treatment is effective)

Prescribing Policy and that there were no significant issues highlighted by the audit. A further cycle of the audit was due to be completed in May 2016 to ensure the standards were being maintained.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

It achieved 96% of the total QOF target in the year ending 31 March 2014, which was above the local area and national averages. Specific examples to demonstrate this included:

- They achieved the maximum scores for indicators relating to asthma, cancer, chronic kidney disease, dementia, heart failure as well as other long term conditions.
- Their performance for diabetes, epilepsy, chronic obstructive pulmonary disease (COPD), mental health, peripheral arterial disease and secondary prevention of coronary heart disease related indicators was similar to or slightly below the local area and national averages.

For the year ending 31 March 2015, the practice achieved an overall QOF score of 93%. The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The practice had also conducted a review of their osteopathy service for January to December 2014. The review highlighted that the service was cost effective, reduced GP appointment times and prescriptions for those referred to the service, and that there was a high level of patient satisfaction among those using the service.

The practice's prescribing rates were also similar to national figures. For the year ending 31 December 2014, the practice had an average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) of 0.18, which was similar to the national average of 0.28. The practice's antibacterial prescription items prescribed per STAR PU was 0.19, which was again similar to the national average of 0.28. The number of Ibuprofen and Naproxen Items prescribed as a proportion of all Non-Steroidal Anti-Inflammatory drugs Items prescribed in the practice was 82.16, whilst the national average was 75.13. The proportion of Cephalosporins & Quinolones Items as a proportion of antibiotic items prescribed in the practice was 5.59, whilst the national average was 5.33.

The practice had a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had a number of outcomes that were better than other comparable practices in the area. For example the latest data from February 2015 showed that their GP initiated first attendance at hospital rate was 167 per 1000, which was significantly better than their peer average of 221 per 1000. The practice minor A&E attendance rate of 27 per 1000 was also significantly better than their peer average of 59 per 1000. Other indicators where the practice performed better than their peer average were emergency admissions rate, patients with long term conditions and smoking status recorded, proportion of patients with body mass index (BMI) greater than or equal to 30 in the preceding 12 months, and their referral rates to IAPT for patients with mental health needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good

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Are services effective?

(for example, treatment is effective)

skill mix among the doctors with additional diplomas awarded to them including sexual and reproductive health, tropical medicine and hygiene, and obstetrics and gynaecology.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice provided them with training and funding for relevant courses to their roles. As the practice was a teaching practice, they accepted fifth year students for placements within the practice.

We saw evidence that the practice provided a number of mandatory training courses specific to staff depending on their roles. For example administrative staff had completed training in summarising and Read coding, and all staff had attended training in infection control and basic life support.

The practice had a system of inducting and mentoring new staff employed in the practice. This involved the new staff members working closely with more experienced staff and learning more about the role on the job. However a newer member of staff we spoke with told us improvements could be made to the training and induction of new staff and there were elements of their role they were not clear about.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were relatively low and similar to expected at 7.87 per 1000 population for ambulatory care sensitive conditions; the national average rate was 14.4 per 1000 population. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held and attended a range of meetings internally and externally relating the operation of the practice and the care of patients.

There were monthly practice meetings attended by the staff team where matters discussed included clinical and practice administration, QOF performance, significant events, patients' complaints and feedback.

Staff in the practice attended external meetings with their peers and their local stakeholders. The practice management attended monthly locality meetings where they discussed and benchmarked their performance against their peers, and quarterly council meetings where they discussed and were able to vote on constitutional matters.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. The practice had a data clerk employed who was responsible for work flowing communications that were received in the practice.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

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Are services effective?

(for example, treatment is effective)

record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice have piloted many IT systems for their then Primary Care Trust (PCT) and now their clinical commissioning group (CCG), including Electronic Prescriptions, T-Quest (electronic pathology requests), EMIS Web (the practice was the first site in Southwark to migrate from EMIS LV to Web), DXS (Decision Support Tool for clinicians) and Windows 7 upgrade.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

Information about a range of health promotion initiatives available to patients were displayed in the practice waiting area.

It was practice policy to offer a health check to new patients registering with the practice who were identified to be at high risk and need. The GP was informed of all health concerns detected during the new patient health checks and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice offered NHS Health Checks, and in the year ending 31 March 2015 they completed 344 checks, which was 203 more than the target set by our local GP federation.

The practice's performance for the cervical screening programme, the proportion of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding five years was 78% for the year ending 31 March 2014, which was slightly below the national average of 81.8%. For the year ending 31 March 2015, the practice performance for cervical screening was 80%, so remained similar to the previous year's performance.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice management team informed us they would be participating in a new scheme with the CCG and local authority to improve bowel cancer screening rates, and were awaiting confirmation of training to be provided about the scheme.

The practice offered smoking cessation services and counselled 58 patients in the year ending 31 March 2015, which exceeded their targets for smoking setters of 42. This resulted in 12 successful quitters. The practice has participated in a pilot with the local authority to offer specific smoking cessation counselling for pregnant patients.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 76%, and at risk groups 51.6%. These were similar to national averages.

Childhood immunisation rates for the vaccinations given to children of two years of age and younger ranged from 83% to 97.6% and five year olds from 77.8% to 100%. These were comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published on 08 January 2015, and the results of the friends and family test.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed that the practice was scored above the local area and national averages for its satisfaction scores on consultations with doctors. For example:

- 92.9% said the GP was good at listening to them compared to the CCG average of 85.2% and national average of 88.6%.
- 90.3% said the GP gave them enough time compared to the CCG average of 81.9% and national average of 86.8%.
- 96.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 93.8% and national average of 95.3%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 CQC comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. Most of the comments cards were entirely positive, with patients saying they received a consistently good service, felt satisfied with the care they received, and that the staff team kept a good attitude, and were helpful and attentive to their needs. Three of the comments cards also included less positive comments but there was no theme to these.

We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Although the practice switchboard was located at the reception desk, the reception area was shielded by glass partitions which helped keep patient information private. Additionally, 83.4% of respondents to the GP patient survey said they found the receptionists at the practice helpful, which was similar to the CCG average of 84.9% and national average of 86.9%.

CCTV monitoring was in use in the practice, and there was a notice about this displayed in the waiting area.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 92.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.4% and national average of 86.3%.
- 87.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76.7% and national average of 81.5%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

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 patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 87.8% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80.5% and national average of 85.1%.
- 87.5% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85.5% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice had participated in a scheme with Southwark CCG to enhance access to information for Carers. The practice hosted a representative from Southwark Carers on the first Monday morning of each month wherein patients can have an appointment or drop in to learn about the support they can receive, including but not limited to benefits advice and respite care advice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the practice provided an osteopathy service, phlebotomy service and particular support services for carers which were all in response to recognised patients' needs.

The practice had a patient participation group (PPG) that met quarterly. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. We spoke with one member of the PPG during our inspection. They told us that the group found the practice amenable to their suggestions and were happy to receive feedback from them. They told us their key contact was the practice manager who they found approachable and felt comfortable discussing matters with them.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Staff told us that the majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

There was ramp access into the building, but there was no signage or mechanism for the main doors into the building to be opened by less able patients.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; and patients could choose to see a male or female doctor.

Access to the service

The practice was open between 8:00am and 6:30pm on Mondays, Wednesdays, Thursdays and Fridays; and between 8:00am and 8:00pm on Tuesdays. Surgery consultation times were between 9am-12:30pm in the morning and 4pm – 6:30pm in the evening. On Tuesdays the practice operated extended hours so that the surgery offered appointments from 8am and was open until 8pm.

The practice offered different types of appointments to suit patient needs: booked, urgent and telephone consultations. There was information displayed in the practice waiting area and in the entrance area to the premises about the appointment times in the practice. The practice also offered online access to appointments, repeat prescriptions requests and aspects of the medical record.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

The patient survey information we reviewed showed patients mostly responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 71.8% described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73.8%.
- 59.7% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 54.3% and national average of 65.2%.
- 95.8% said they could get through easily to the surgery by phone compared to the CCG average of 75.4% and national average of 74.4%.
- 66.4% were satisfied with the practice's opening hours compared to the CCG average of 74.6% and national average of 75.7%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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, the practice manager, who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, in the form of a complaints leaflet, a section referring to how to make complaints in the practice leaflet and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the four complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaints.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care within accepted evidence based practice, and to expand the practice and the services offered. We found details of the vision and practice values were part of the practice's statement of purpose.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The practice's business manager was the lead for review and update of the practice suite of policies and procedures. They told us the changes to policies and procedures were circulated among the staff team and discussed at staff meetings.

We looked at a number of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. Most of the policies and procedures we looked at had been reviewed within their specified period and were up to date. We found the practice adult safeguarding policy was in need of review and update.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The members of staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. However a more recently appointed member of staff highlighted that some greater formalisation of the induction period would make the fulfilling of heir day to day role easier.

The GP, business manager and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing above the local area and national overall. For the 2013 / 14 year, the practice achieved an overall QOF score of 96.1%, and for 2014 / 15 they achieved 93% overall. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example evidence from their prescribing practices, incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the local CCG.

The practice identified, recorded and managed risks. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. However, whilst in the past they had contracted external companies to carry out disability discrimination act assessments and fire risk assessments on their premises and operational arrangements, the latest assessments completed had been stated by the contractors as being due for re-assessment in 2013.

The practice held monthly practice meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed the recruitment policy that was in place in the practice, and found that the practice also had a whistleblowing policy to support staff with raising any concerns. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Are services well-led?

Good

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

The lead GP and senior management staff in the practice was visible and staff told us that they were approachable and always take the time to listen to all members of staff.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We saw from minutes that the last practice meeting was held the week before our inspection. However, prior to that the last practice meeting had been held in October 2014.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice had been taking part in the Friends and Family Test (FFT) since December 2014. The most recently reviewed FFT results, from patient feedback provided in January 2015, showed that 18 of the 19 respondents were likely to recommend the practice to friends and family.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP teaching practice, and accepted third year medical students for placements. One of the practice GPs was the lead for this element of the practice's services.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.