St Mary's Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Mary's Surgery on 29 April 2015. This was the only location inspected. The provider currently has one other registered location, which is Bargate Medical Centre and also operates from a branch location at Telephone House Surgery and these premises were not inspected as part of this visit.

Overall the practice is rated as good.

Specifically we found the practice to be rated as good for providing caring, effective and well-led services. We found the service to be outstanding for providing a responsive service. We found the practice to require improvement for providing safe services.

The practice was rated as good for providing services to 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 were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Learning from incidents was maximised.
- The practice used innovative and proactive methods to improve patients' outcomes. Multi-disciplinary team meetings were held to discuss the provision of care to those patients who had been identified as at risk and staff shared information with the clinical commissioning group.
- Information from patients indicated that they were mostly satisfied with the care that they received and were involved in their care and decisions about their treatment.

Summary of findings

- The practice had responded to feedback from patients and made changes to the way that it operated as a consequence of this.

We saw several areas of outstanding practice including:

- The practice had outstanding systems in place to manage and review the risks to vulnerable children and young people. These included a template for the management of safeguarding that had been implemented across the clinical commissioning group for all practices in the area.
- The practice had systems in place to provide information and improve access to care for patients who did not speak English as a first language and had supported women from the local Afghan Community to access healthcare.
- The practice provided additional support to patients who misused substances.
- The practice paid to provide an additional 15 hours of counselling each week that could be accessed by patients who would otherwise not be eligible to receive a counselling service.

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

Importantly, the provider must:

- Ensure that the fire door meets the requirements of fire safety. Emergency doors must not be so locked or fastened that they cannot be easily and immediately opened by any person who may require to use them in an emergency.
- Update the chaperone policy and either provide a check via the Disclosure and Barring Service (DBS) for nurses, healthcare assistants and reception staff that chaperone or put a risk assessment in place for those staff who do not have a DBS check but who chaperone patients.

In addition the provider should:

- Update the accident and incident reporting policy to include information about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Document action taken on receipt of alerts from the Central Alerting System.
- Update the practice information leaflet so its contents are current and accessible to patients.
- Ensure that policies and procedures on infection prevention control are reviewed in accordance with the specified review date and provide a policy and risk assessment for the management of legionella.
- Review policies and procedures on sharing information to ensure that patients can be confident that information will not be shared without their consent.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Alerts from the Central Alerting System were received and cascaded to staff, however there were no systems in place to record the actions taken by staff when an alert was received.

A fire risk assessment was in place which had been conducted on 29 October 2009, but a fire door had been bolted. There were some policies and procedures in infection control and the management of legionella, (a bacterium that can grow in contaminated water and can be potentially fatal) that had not been updated and fully implemented. However, the practice did have outstanding systems in place to manage and review the risks to vulnerable children, young people and adults. These had been implemented by the clinical commissioning group across all practices in the area.

The practice had a recruitment policy that set out its standards when recruiting clinical and non-clinical staff. The policy included a list of checks that was carried out before a person was employed including completing a criminal records check via the Disclosure and Barring Service (DBS). We found that all GPs had had a DBS check, but these had not been completed for other staff who worked at the practice, including those who chaperoned patients. Risk assessments had not been carried out to indicate whether a DBS check was needed.

Are services effective?

Good

The practice is rated as good for providing effective services. Patient needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice had created clinical pathway assessment templates to help staff to assess the needs of patients and manage the risks associated with some clinical conditions. Staff had received training appropriate to their roles. Information for patients about the service was not always available, for example, a practice information sheet was updated in August 2014 and provided information about opening times appointments, home visits, out of hours emergency procedures and the complaints process but was not routinely accessible to patients at the time of our visit.

Summary of findings

Are services caring?

Good

The practice is rated good for providing caring services. Data from patients satisfaction surveys and feedback from patients showed that patients were happy with the service that they received and felt listened to by GPs. We saw that patients were treated with kindness and respect and involved in decisions about their care and treatment. There were systems in place to respect the privacy and dignity of patients.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. The practice had implemented improvements and made changes to the way that it delivered services in response to patients' feedback. Over 25% of the patients at the practice did not speak English as a first language and the practice had worked with a local radio station catering to the ethnic minority communities in the area, to provide information to the local population.

The practice supported patients who misused substances and reviewed them every six months with a substance misuse counsellor. The practice paid to provide an additional 15 hours of free counselling each week, that could be accessed by patients who would not otherwise be eligible for access to counselling services. There was a proactive approach to understanding the needs of different groups of people and delivering care in a way that met patients needs and promoted equality.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had mission statement and partners had regular meetings to discuss the vision and strategy of the practice and these meetings were minuted. There was a clear leadership structure and staff felt supported by managers. There were systems in place to monitor and improve quality and identify risk. There were systems in place to manage, monitor and improve the provision of services at the practice. The practice had actively sought feedback from staff and patients, which it acted on.

The practice had a number of policies and procedures to govern activity and held governance meetings, however we found some policies and procedures were not in place or had not been updated to reflect the most up to date information. The accident and incident reporting policy had been reviewed on 26 February 2015

Summary of findings

but had not been updated to include all relevant information. A staff handbook was available on the intranet, which had been updated in February 2013, not all staff had signed to indicate that they had read the handbook.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice offered proactive personalised care to meet the needs of older people in its population and had a range of enhanced services available. All patients over the age of 75 had a named GP. The practice provided a 60 minute health check for all patients over the age of 75 and had created a screening tool to record information as part of the health check. Older patients with complex needs had a care plan in place.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. All patients with long term conditions had an annual review and medication check. A specific template had been created to record care and identify risks to patients with long-term conditions such as diabetes and chronic obstructive pulmonary disease (COPD). Nurse led specialist clinics were held for patients with diabetes, asthma and COPD. Home visits were available for patients that could not access the surgery.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify and follow up on those children and young people, who were at risk, including systems to identify and manage risks to the unborn child. An extended appointment service was available to provide appointments for school age children. The practice provided appointments on the same day for children and a children's phlebotomy (blood taking) service was available on site. There was a health visitor clinic held at the site and the health visitor offered drop in clinics and first time parent classes.

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 practice provided care to a large student population. A total of 69% of the practice population were under the age of 35. The practice provided an extended hours service with GPs and nurses and telephone consultations were available. Repeat prescriptions and appointments could be requested on-line. Same day appointments were available every day and this helped people to get medical care quickly so that they could return to work. The practice had run a

successful cervical screening campaign and this was supported by additional nurse clinics. This had increased the number of women who received cervical screening to 89.97% compared to the national average of 81.89%.

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 had created a safeguarding referral template and their safeguarding procedures had been implemented across the clinical commissioning group. Clinical alerts were placed on the system to identify patients whose circumstances made them vulnerable and staff had attended a practice based domestic violence and abuse training support and referral programme and completed training in communication.

Patients who had complex care needs were placed on a practice register and an admission avoidance scheme was in place. This had been put in place in response to a high number of hospital admission reported in 2013 to 2014. The number of emergency cancer admissions per 100 patients on disease register was 38.1 compared to the national average of 7.4. GPs told us that this had been reduced and patients receiving palliative care were placed on an end of life register and had two named GPs. Multi-disciplinary meetings were held with the district nursing team. The practice had increased the number of additional locum sessions from four sessions to seven sessions during the winter months and put in place a system where patients could be seen on the same day or early the next day to reduce the number of patients using out of hours services.

Over 25% of the practice population did not speak English as a first language. Staff had worked with a local voluntary organisation, which provided a radio station, catering to the Asian and ethnic minority communities in the area, to provide information to the local population about how to access the practice, influenza management and childhood immunisations. The practice had provided support to access healthcare to women in the local Afghan community. A GP told us that he met with a local Somali leader to provide information and discuss access to healthcare for the local Somali population. The practice had an automated check-in service, which could be operated in ten different languages. Translators and sign language support service were available.

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. People who were experiencing poor mental health were supported by look after their physical health. A total of

Summary of findings

93.8% of patients with poor mental health had their alcohol consumption discussed with them in the last year. A template had been instigated to assist in the assessment and documentation of care provided to people with poor mental health and their ability to make decision. A register of people experiencing poor mental health was available. All patients who did not attend for appointments were contacted by telephone.

The practice provided funding for fifteen hours of one to one counselling each week, which was made available to those patients who would not otherwise be eligible for a counselling service through any other route. Patients were encouraged and supported to access other services such as substance misuse services. A GP acted as lead for supporting patients who misused substances. This involved providing shared care controlled prescribing, with patients being reviewed every six months by the GP and a substance misuse counsellor.

A dementia screening tool had been created and was being used to assess patients who were at risk of dementia.

Summary of findings

What people who use the service say

The practice had participated in the national Friends and Family test and cumulative data from January to March 2015 for this test indicated that 154 patients responded to the survey. A total of 93.5% of patients who responded to the survey indicated that they were likely or extremely likely to recommend the practice to their friends and family.

The practice had conducted their own satisfaction surveys in December 2014, January and February 2015; asking patients who used the service how satisfied they were with the care they had received during their visit. This survey indicated that 89.5% of patients were very satisfied with their care.

A total of 13 reviews had been posted on the NHS Choices website in the 12 months prior to the inspection. Three reviews were positive but the others were negative and focused on the inability to book an appointment and the rudeness of reception staff. The practice had responded to the majority of reviews posted and taken action to manage the issues that had ben raised.

We received 32 comments cards from patients who use the service. All of the 32 cards were positive and patients commented on the good services provided at this location and the high quality of care provided by staff. One comment card did indicate that it was difficult to book an appointment.

We met a member of the patient participation group. They indicated that they had participated in a virtual meeting and that the group was in the early stages of formation.

We spoke to eight patients during our visit. One patient told us about how the practice had supported them when they required urgent care and had required paramedic assistance. All patients said that the care provided was excellent and most said it was generally easy to get an appointment. However two patients indicated that it was not always easy to get an appointment with a named GP. Patients said they were involved in decisions about their care and were listened to by their GP. One patient said that the GPs do not always have enough time. Two patients said they had been referred to hospital for further treatment in a timely manner.

Areas for improvement

Action the service MUST take to improve

Importantly, the provider must:

- Ensure that the fire door meets the requirements of fire safety. Emergency doors must not be locked or fastened so that they cannot be easily and immediately opened by any person who may require to use them in an emergency.
- Update the chaperone policy and either provide a check via the Disclosure and Barring Services (DBS) for nurses, healthcare assistants and reception staff that chaperone or put a risk assessment in place for those staff who do not have a DBS check but who chaperone patients.

Action the service SHOULD take to improve

In addition the provider should:

- Update the accident and incident reporting policy to include information about the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Document action taken on receipt of alerts from the Central Alerting System.
- Update the practice information leaflet so its contents are current and accessible to patients.
- Ensure that policies and procedures on infection prevention control are reviewed in accordance with the specified review date and provide a policy and risk assessment for the management and monitoring of legionella.
- Review policies and procedures on sharing information to ensure that patients can be confident that information will not be shared without their consent.

Summary of findings

Outstanding practice

We saw several areas of outstanding practice including:

- The practice had outstanding systems in place to manage and review the risks to vulnerable children and young people. These included a template for the management of safeguarding that had been implemented across the clinical commissioning group for all practices in the area.
- The practice had systems in place to provide information and improve access to care for patients who did not speak English as a first language and had supported women from the local Afghan Community to access healthcare.
- The practice provided additional support to patients who misused substances.
- The practice paid to provide an additional 15 hours of counselling each week that could be accessed by patients who would otherwise not be eligible to receive a counselling service.

St Mary's Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a second CQC inspector, a specialist practice manager and an expert by experience. Experts by experience are members of the inspection team who have received care and experienced treatment from a similar service.

Background to St Mary's Surgery

St Mary's Surgery is located at 1 Johnson Street, Southampton. SO14 1LT, which is close to the centre of Southampton. The location has 13 consulting room and three treatment rooms. The location provides care and treatment to approximately 23,000 patients across three sites, of which 19,000 are registered at St Mary's Surgery. The 19,000 patients that are registered at St Mary's Surgery can also be seen at Telephone House branch surgery.

The practice is open from 8.30am to 6.30pm Monday to Friday. Additional extended hours are offered at St Mary's Surgery between 7.30am and 8am on Thursdays and at Telephone House Surgery on Monday and Thursday evenings until 8pm and Saturday mornings between 8.30am and 11am. These are for prebooked appointments only. Telephone lines are open at St Mary's Surgery on weekdays from 8am.

The area has a large student population and a higher than average number of patients between the ages of 18 and 35 years. Over one quarter of patients do not speak English as their first language.

The practice employs a total of 69 staff, many of whom work across all three locations. Staff include five GP partners, eight salaried GPs, ten nurses and five healthcare assistants. Three GPs are male and ten GPs are female. The practice has a Personal Medical Services (PMS) contract and is also a training practice.

The provider operates from St Mary's Surgery and at Bargate Medical Centre 1 Spa Road, Southampton, Hampshire, SO14 2EG. The provider also operates clinics from Telephone House Surgery, 70-75 High Street, Southampton, Hampshire, SO14 2NW as a branch location. Patients who are registered at St Mary's Surgery can also access appointments at Telephone House Surgery.

The practice has opted out of providing out-of-hours services to their own patients. Patients can obtain out of hours care using the 111 service and care is provided by Hampshire Doctors on call.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We received information from other organisations such as NHS England, Healthwatch and Southampton Clinical Commissioning Group. Prior to the inspection, we asked patients to share their views by completing comments cards for us to review.

Detailed findings

We carried out an announced visit on 29 April 2015. During our visit we spoke with a range of staff including GPs, the practice manager, practice nurses, healthcare assistants, receptionists and administration staff. During the visit we observed how people were being cared for and talked with patients and family members. We reviewed the premises to see if they were safe and accessible. We reviewed documentation, policies and procedures. We reviewed incidents and complaints to see if they had been investigated and acted upon.

We asked 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 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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve the safety of patients and staff, including reported incidents and 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, the practice had three significant events related to medicines being prescribed which patients were allergic to, despite alerts being in place on the patient record. The recording system had been updated to add an additional prompt when prescribing, when a patient had a known allergy. This alerted the GPs to ensure medicines were prescribed safely.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. 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 systems in place for reporting, recording and monitoring significant events. We reviewed 22 significant events that had occurred since April 2014. The practice had identified learning outcomes from significant events and taken action to improve the service as a result of the learning identified. For example, a child had a high temperature and the GP had not carried out a urine test to identify whether there was an infection. The process for dealing with febrile children had been updated as a result of this incident. This protocol was shared across the Clinical Commissioning Group (CCG).

Significant event meetings included staff from all areas of the practice, including the reception manager and meetings and learning outcomes had been documented. For example, an incident occurred where staff had not followed the correct procedure when carrying out a pregnancy test. We saw that this incident had been reviewed and discussed at a practice meeting. Staff had received further information and training as a result of this incident and learning notes from this training were available on the practice intranet.

Alerts from the National Patients Safety Agency were received and cascaded to staff, however there were no systems in place to record the actions taken by staff when an alert was received.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review the risks to vulnerable children, young people and adults. The practice had nominated a safeguarding lead and a deputy safeguarding lead. Training records showed that all GPs, apart from one, had received safeguarding training for children at the appropriate level and all staff had received safeguarding adults training.

Staff were able to demonstrate their understanding of safeguarding and what they would do in the event of a concern being identified. Safeguarding procedures in the practice had been assessed using a safeguarding risk tool, which scored areas which might need action. We looked at the risk tool and found that measures were in place to minimise risks to patients as far as practically possible and there were no areas identified which required attention at the time of our inspection.

The practice safeguarding policy set out whom referrals were made to for further action and contained contact details of relevant agencies, such as the local authority. In addition, if needed information was also shared with antenatal care providers if the risk was to an unborn child. Multi-disciplinary safeguarding meetings were held every three months. We reviewed a template that had been developed to assist in recording, coding and monitoring safeguarding information. We saw a letter from the named doctor for safeguarding children and adults at Southampton CCG dated 25 April 2015. The letter acknowledged exemplary safeguarding procedures at the practice and identified that the practice safeguarding templates were now being used across the CCG. There had been an 18% increase in the number of children on the practice safeguarding register in the last 12 months since the procedure had been updated.

There were systems in place to highlight vulnerable patients on the practice electronic records. This included children who did not attend for hospital appointments. Staff would contact the parents of young children and if a

teenager did not attend for an appointment, staff would try to contact them directly. This was added to a task list and was not removed from the list until the patient had been contacted.

The standard examination and consultation template had been amended to highlight those who may pose a risk to themselves or others and prompted staff to ask relevant questions.

A chaperone policy was available and contained details of the procedure that should be followed should a patient require a chaperone. We found that the policy was not dated and we were unable to ascertain whether the policy was fit for purpose. Signs were displayed in the waiting areas and treatment rooms inviting patients to request a chaperone. Chaperones were offered to both male and female patients. There was a template for recording the name of the person who had chaperoned in the patient records. Nurses and healthcare assistants acted as chaperones and reception staff acted as chaperones if nursing staff were not available. The staff that we spoke to had been trained and were clear about their role. Nurses, healthcare assistants and reception staff who acted as chaperones had not had a criminal records check carried out via the Disclosure and Barring Service (DBS). Risk assessments had not been carried out to indicate whether a DBS check was needed.

Medicines management

We checked medicines stored in treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. Fridge temperatures were monitored and a record of fridge temperatures was in place. GPs had a doctor's bag, which contained small quantities of medication. There was a list of medication held in the bags and the medication expiry dates were recorded and monitored. There were appropriate arrangements in place to dispose of unused or expired medicines in line with waste control guidance.

Emergency medicines and equipment were available for both adults and children, we found they were all within their expiry date.

The practice had had three significant events related to medicines being prescribed which patients were allergic to, despite an alert being on the patient record. The recording system had been updated to add an additional prompt when prescribing, when a patient had a known allergy. This alerted the GPs to ensure medicines were prescribed safely.

The practice had systems in place to manage repeat prescriptions. Repeat prescriptions could be brought into the practice or requested on line. All prescriptions generated were reviewed and signed by a GP prior to being given to patients. A computer alert indicated when patients were due for a medication review, which was then carried out by a GP in consultation with the patient. Blank prescription pads were stored securely and in accordance with national guidelines.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. A contract for cleaning was in place; however, there was no schedule of cleaning available for contract cleaners. Cleaning was reviewed every two months at a meeting with the contactors. We saw copies of cleaning reviews that had been completed by the contract cleaning company on 27 April 2014, 18 February 2015 and 12 December 2015. Comments for action had been recorded on the audits and actions had been completed.

There was an infection control policy in place which had a date for review of October 2014. The policy had not been reviewed at this time. The policy covered key areas of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance 2010. There were separate policies for handling sharps and disposing of them safely. An infection control audit checklist was available and this had been reviewed on 23 April 2015. The audit checklist was not fully completed.

The practice had a lead person for the management of infection control. This person had received training through the Wessex Local Medical Committee. We saw training records that indicated that all staff received training in infection control as part of the induction process and on an annual basis.

A member of staff told us that protected time was made available at the end of each clinical session so that staff could clean treatment rooms. The practice used single use

disposable equipment. There were systems in place for the disposal of hazardous waste. Sharps bins had the date on which they were opened written on the front, in line with best practice guidance.

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

Floors in the treatment rooms had been replaced and were washable, apart from one treatment room that had carpet in place but there were no surgical or clinical procedures performed in this room, we saw the carpet was clean. There was a programme in place to replace all carpets with wipe clean flooring. Privacy curtains in treatment rooms were disposable and had been changed within the last six months. We saw invoices for carpet cleaning that had been completed on a six monthly basis. Policies in place for the management of blood and body fluid spillages had a review date of 1 October 2014 but this review had not been completed. Cleaning kits were available to clean body fluid spillages from both carpets and hard flooring.

The practice did not have a policy in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A legionella risk assessment had not been completed and legionella testing had not been carried out.

Equipment

All portable electrical equipment was routinely tested and we saw records that indicated it was last tested on 18 February 2015. We saw evidence of maintenance and testing of equipment, for example, records confirming that weighting scales were serviced on 11 September 2014. There was a blood pressure monitor in reception. The machine was calibrated and serviced on 15 April 2015 (Calibration is when a piece of equipment is tested to ensure it measures accurately).

Staffing and recruitment

The practice had a recruitment policy that set out its standards when recruiting clinical and non-clinical staff. This had been reviewed on 24 April 2015. We saw that a list of checks that was carried out before a person was employed, which included evidence of conduct in previous employment in the form of references; proof of qualifications; and registration with the appropriate professional body. The list included completing a criminal records check via the Disclosure and Barring Service (DBS). We found that all GPs had had a DBS check, but these had not been completed for other staff who worked at the practice. Risk assessments had not been carried out to indicate whether a DBS check was needed.

The practice had systems in place for planning and monitoring the number of staff and mix of staff needed to meet patient's needs. Staff told us that the practice usually provided an extra four locum sessions during the winter months but they had increased this and provided an additional seven locum sessions per week to respond to the increase in demand for appointments between December 2014 and March 2015. The practice had also recruited two new members of staff to work on reception during identified peak times.

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 checks of the building, environment risk assessments, medicines management, staffing, dealing with emergencies and equipment. The practice had reviewed the action to be taken if vaccines could not be stored at the correct temperature and if the cold chain was not maintained. (Cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the patient).

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had completed cardio pulmonary resuscitation training on 8 July 2014. Emergency equipment was available for both adults and children, including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Emergency medicines we checked were all within their expiry date. We spoke to a patient who said that they had previously arrived at the surgery with a suspected heart attack. The patient told us that staff had responded appropriately, supported them throughout the incident and called an ambulance. We observed that a GP had called an ambulance for another patient who had been

taken ill. They sent an electronic message to reception to staff to alert them that the ambulance had been requested and that paramedics should be sent straight to the consultation room.

Staff told us that they had received training in Identification and Referral to Improve Safety. This was a practice based domestic violence and abuse support and referral programme. If a patient posed a risk to staff or other patients the practice referred them to the violent patient scheme at the Royal Southampton Hospital. The practice had an alarm in place to summon help in an emergency. The alarm went to a member of staff who deals with security. A second alarm went straight to the Police. Staff had received training in communication to help them talk to patients that were anxious or aggressive. During our visit we saw that a patient had become aggressive and staff had talked to the patient calmly and pressed the alarm. Security staff responded appropriately. We noticed that the situation was handled swiftly and discretely and other patients in the waiting room were not alarmed.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan had been updated in February 2015. Risks identified included loss of computer systems, loss of key staff, failure of telephone systems, inability to access the building, damage to the building, loss of electricity and flood or loss of water supplies. The computer system was backed up and there was a laptop and paper records available for essential use. The business continuity plan included roles and responsibilities of key staff in the event of an incident. The plan identified that patients could be seen at Telephone House Surgery.

We observed that fire extinguishers were serviced on 23 June 2014 and saw the invoice where testing had been paid for. A fire risk assessment was in place. However, we saw a fire door that had been fitted with a bolt at the bottom. This meant that the door could not be easily and quickly opened in the event of a fire.

CCTV cameras were in place in the reception area in public areas. There were no signs inside the building to identify that CCTV was in operation.

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. GPs and practice nurses worked in accordance with guidelines from the National Institute for Health and Care Excellence (NICE) and guidance from local commissioners, these were accessible to all staff on the practice intranet system. Staff we spoke with demonstrated a good level of understanding and knowledge of NICE guidelines and local guidelines.

Staff described how they carried out comprehensive assessments of patient's health needs in accordance with NICE guidelines. They explained how care was planned to meet patients required needs and how patients were reviewed to make sure that their treatment remained effective. Patients with chronic diseases or who had been flagged as part of the hospital admission avoidance scheme had individual recall dates for full reviews and a medication check.

The practice had developed local clinical pathway assessment templates, to assess the needs of patients with Chronic Obstructive Pulmonary Disease (COPD), diabetes and hypertension (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections). We saw templates to assist in the recording of spirometry tests (a spirometer measures lung function including the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function). GPs told us they lead in specialist clinical areas such as chronic disease management, diabetes and mental health and nurse led specialist clinics were in place to support work on diabetes, asthma and COPD. The GP who led on diabetes management attended an update course annually.

Emergency admissions to hospital were reviewed as part of the admissions avoidance scheme to ensure that any admission to hospital was relevant.

Discrimination was avoided when making care and treatment decisions. Discussions with staff indicated that the culture of the practice was that patients were 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 outcomes was monitored routinely. This information was used to improve care. The practice had a system in place for completing clinical audit cycles. We reviewed four clinical audits that had taken place in the last year. An audit of minor surgical procedures was completed in January 2015, which reviewed infection and complication rates of 20 minor surgical procedures. The audit identified an infection rate of 5% but the wound was already infected prior to surgery and a further three patients were not suitable for surgery at the practice and referred to hospital for surgery. An audit of Pregablin prescribing was started in July 2014 (Pregablin is a medicine which is used to treat neuropathic pain, anxiety disorder and epilepsy). The audit showed an improvement in the effective prescribing of Pregablin since initial data was collated in August 2014 and identified actions to achieve further improvement.

The practice monitored the care provided to specific patients groups, in particular patients with diabetes and patients experiencing poor mental health. We reviewed data for diabetes management from the quality 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). Indicators for the management of diabetes were slightly higher than the national average, indicating that the practice was performing well in this area. All patients who did not attend for appointments for diabetes care were contacted by telephone. QOF data for 2013/ 2014 indicated that 100% of patients with atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), measured within the last 12 months were currently being treated with anti-coagulation (blood thinning) therapy or antiplatelet therapy (medicines that stop blood cells from sticking together and forming a blood clot). QOF data also indicated that 89.97% of women aged 25 to 65 years old had received a cervical screening test in the last 5 years.

The practice was aware of areas where performance was not in line with national and CCG figures. They identified that there were a number of patients who were prescribed anti-coagulants, who had a hospital admission which had not been necessary. The practice introduced the INR Star

Good

Are services effective?

(for example, treatment is effective)

system (a management system used to assist healthcare professionals with the treatment of patients on anticoagulants). However, GPs told us that using the system had not resulted in a significant reduction in the number of hospital admissions for anticoagulant patients, which was still higher than the national average.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess and improve the performance of clinical staff. Multidisciplinary team meetings were on a weekly basis and minuted. Areas covered included significant events, complaints and staff training. For example, an incident where staff had not followed the correct procedure when undertaking a pregnancy test. Learning from this incident had resulted in procedures being updated and learning outcomes were made available to all staff on the practice intranet.

The practice prescribing rates were similar to national figures. There was a policy for repeat prescribing, which was in line with national guidance. A computer alerting system was used in place to ensure that repeat prescriptions had been reviewed by a GP, prior to being given to the patient.

The practice kept a register of patients receiving palliative care. Each person on the register had two named GPs. Multi-disciplinary meetings were held with the district nursing team to discuss the care and support needs of patients and their families. A template was in place to record patients' decisions around do not resuscitate directions. These templates contained a link to the gold standards framework for end of life care.

The practice kept a register of those patients who were vulnerable such as patients with learning disabilities. All patients with long term conditions, such as diabetes and COPD had an annual review and medication check. Patients who were homeless accessed treatment at the location and the practice address was used as a point of contact for referral letters. Patients were also directed to homeless support services in the area.

Effective staffing

Practice staffing included GPs, nurses, healthcare assistants, managerial and administrative staff. We reviewed staff training records and saw that training was scheduled to ensure that staff were up to date with required training. Records indicated that all staff had completed cardio pulmonary resuscitation training on 8 July 2014. We spoke to a member of the administration team who said they received induction training and mandatory training including dementia training, fire training and training in patient confidentiality and information governance. They said they had protected target training days every three months. (Target training days are set by the clinical commissioning group to provide mandatory training to staff).

Clinical staff had protected time for training on Monday mornings. Training for GPs included clinical sessions on Ebola, safeguarding and paediatric nutrition. GPs had specialist areas of expertise such as chronic disease management, diabetes and mental health.

Staff records showed that staff received annual appraisals and included a summary of their continuous professional development. Appraisals for GPs included feedback from staff as well as peer reviews from other GPs. GPs were up to date with their yearly continuing professional development requirements and had completed the revalidation process or were in the process of revalidating. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every 5 years). The practice was last accredited as a GP training practice on 2 September 2013. We received positive feedback from the current trainee, who said that he had recommended the practice to his peers.

Where poor performance had been identified appropriate action had been taken to manage this. Trends analysis of complaints indicated that patients thought that some reception staff were sometimes rude. Staff had received training in communication and dealing with patients who became frustrated and upset. We saw staff used this training when addressing a patient who was being verbally abusive.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those patients with complex needs. It received blood test results, letters from the local hospital including discharge summaries and information from out of hours services both electronically and by post. All information received was scanned into the electronic system. Information was passed to a named GP to be

Good

Are services effective?

(for example, treatment is effective)

reviewed and actioned on the date of receipt. Staff told us that if the named GP was away then test results would be passed to another GP for review and filed in the patient record once all actions had been completed.

Emergency admission rates for patients with cancer were high at 38.1 per 100 patients on the disease register compared to the average of 7.4 per 100 patients on the disease register. However, emergency admission rates for 19 ambulatory care sensitive conditions were similar to expected at 11.3 per 1,000 population compared to the national average of 13.6 per 1000 of the population (ambulatory care sensitive conditions are conditions for which effective management and treatment should prevent admission to hospital). GPs told us that they had taken steps to reduce this by increasing the number of locum sessions available and by providing a system so that patients can be seen by a GP on the same day or the next day. The practice reviewed emergency admissions as part of the admissions avoidance scheme and identified whether the admission could have been prevented. This had led to a reduction in the number of hospital admissions. As a result of a review of contact with secondary care services, such as the hospital, the practice had increased the number of appointments available to patients on the same day. The practice had noted a decrease in the number of patients who were using accident and emergency services.

Other patients who had contact with the hospital or our of hours GP service were reviewed by the duty GP when information was received and appropriate action taken. An electronic task system was used to set a follow-up action for reception staff, for example, if a patient needed a follow-up appointments after discharge from hospital. We were told this system worked well. However, there was one recorded incident in the last 12 months, where the instructions in a discharge letter had not been actioned. This incident was reviewed at a clinical meeting and learning outcomes identified.

Multi-disciplinary team meetings involving district nurses were held on a weekly basis. Areas discussed in these meetings included care, treatment and support to patients with long term conditions, patients who were vulnerable and patients receiving palliative care. Multi-disciplinary safeguarding meetings were held every three months and if there was an identified risk to an unborn child, safeguarding information was shared with antenatal care providers and other relevant agencies.

There was a nominated GP responsible for supporting patients who misused substances, such as drugs and alcohol. Treatment was offered in conjunction with support from local substance misuse services. For example, shared care controlled prescribing was in place, with patients being reviewed every six months by the GP and a substance misuse counsellor.

Information sharing

The practice used electronic systems to communicate with other providers and an electronic patient record was used to coordinate, document and manage patient's care. All information that came into the practice by letter was scanned into the system and filed electronically. The practice used the choose and book system to make electronic referrals. Staff had received training on electronic systems and this was documented as part of the induction process.

We saw that the practice had created practice specific pathway assessment templates. We reviewed a template that had been developed to assist in recording, coding and monitoring safeguarding information. We saw a letter from the named doctor for safeguarding children and adults at Southampton Clinical Commissioning Group (CCG) dated 25 April 2015. The letter acknowledged exemplary safeguarding procedures at the practice and identified that the practice safeguarding templates were now being used across the CCG.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Patients were supported to make decisions about their care, through the use of care planning and care reviews. QOF data for 2013/ 2014 indicated that 92% of patients with dementia had received a face to face care review in the last 12 months and this is higher than the national average of 83.83%. GPs told us that they used a best interest procedure and worked in conjunction with the elderly care physician and the patient's family. A template was in place to record patients decisions around do not resuscitate planning and this contained a link to the gold standards framework for end of life care.

Good

Are services effective?

(for example, treatment is effective)

Staff that we spoke to had a clear understanding of the Gillick competence test. (Gillick competencies are used to help assess whether a child age 16 years or under, had the maturity to make their own decisions and to understand the implications of those decisions). Templates had been generated to assist staff in assessing and recording a patient's ability to consent to treatment under the mental capacity act and Gillick competence for those patients under the age of 16.

There was a procedure for documenting consent to specific interventions, for example, minor surgical procedures; a patient's verbal consent was documented in the electronic patient record, as well as a written consent form being completed.

Health promotion and prevention

The practice offered health checks for patients between the ages of 40 and 65 and identified patients who needed additional support. There was a culture among the GPs to use their contact with patients to improve their mental, physical health and wellbeing. QOF data indicated that 93.8% of patients with poor mental health had their alcohol consumption discussed with them in the last year. Smoking cessation advice was offered to patients who smoked.

The practice offered a range of vaccinations for children, in line with national guidance. Last year's performance for vaccinations was slightly below the national averages. Flu vaccination rates for patients aged 65 and older were 71.22% compared with the national average of 73.24%.

The practice paid to provide an additional 15 hours of counselling each week and this could be accessed free of charge by patients who would not otherwise by eligible for counselling services.

Health visitor clinics were held at the site, and included drop in clinics and first time parent classes. Health visitors had been working with practice staff on a "milk to meals" initiative to educate new mothers, particularly in black and ethnic minority groups, on potential nutritional deficiencies when a baby was solely breastfed. Iron supplementation rates had decreased by three per cent.

Staff told us that they had worked with a local voluntary organisation, which provided a radio station, catering to ethnic minority communities in the area. Discussions were translated into Farsi, Dari and Polish. Staff had taken part in a radio programme that provided information to the local population about how to access the practice, influenza management and childhood immunisations. They had provided health advice to women in the local Afghan community.

A television screen in the waiting room provided information about local services to patients. Information available in the waiting room included information about out of hours services, how to book appointments and extended hours. Patient information leaflets, available in consulting rooms, included smoking cessation and diabetes management. A patient folder was available in reception, containing some information for patients such as the patient's charter but this was not easily accessible to patients and was not signposted for patient use. A practice information sheet, updated in August 2014, was not routinely accessible to patients at the time of our visit.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed data from the practice patient satisfaction survey conducted in December 2014, January 2015 and February 2015. Data indicated that 89.5% of patients were very satisfied with their care.

The evidence we reviewed showed that patients were happy with the care they received, however data from the 2014 NHS England GP survey indicated that patients were less satisfied with the care they received than the national average, for example, the proportion of respondents to the GP patients survey who described the overall experience of their GP practice as fairly good or very was 64.73% compared to the national average of 85.76%. GP's told us how they had responded to patient feedback in order to improve the service available to patients, for example, they had increased the number of locum sessions and same day appointments available to patients.

Patients completed CQC comments cards to tell us what they thought about the practice. We received 32 completed comments cards and the majority were positive about the service provided and their experience. Patients commented on the good services and the high quality care provided at the practice. One card indicated that it was difficult to book an appointment. One patient said they had received good personalised care from the surgery. Another patient who had been supported through a medical emergency told us how well they had been supported throughout the incident. We spoke to eight patients during our visit who said that they felt involved in decisions about their care and listened to by their GP. A patient told us that the GPs do not always have enough time.

We saw that consultations and treatments were carried out in the privacy of a consulting room. Disposable privacy 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.

There was a confidentiality policy in place. Staff told us that they had received training in confidentiality and information governance as part of their induction training and as update training. We saw that staff respected patient's confidentiality when discussing patients' treatments.

The 2014 NHS England – GP Patient Survey indicated that the proportion of respondents to the GP survey who stated that in the reception area other patients can't overhear was 4.29% compared with the national average of 9.23%. The reception was large and open plan in design. There was a radio in the waiting area which helped to protect confidentiality. This had been put in place in response to a survey. Patients were requested to approach the reception one at a time which helped to promote privacy. There was a shielded hatch at the side of the reception where the language line translation service could be accessed. We observed that a patient who did not speak English was directed to the hatch to use this.

Staff had received training to help them identify and support patients who had been involved in domestic violence.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour they would report this to the practice manager. Staff had attended communication training to help to assist in the management of aggressive patients. If a patient posed a risk to staff or other patients the practice referred them to the violent patient scheme at the Royal Southampton Hospital. During our visit we saw that a patient had become aggressive, staff had talked to the patient calmly and pressed the panic alarm. A member of security staff had responded and the situation was handled swiftly and discretely.

Care planning and involvement in decisions about care and treatment

We spoke to eight patients who said that they felt involved in decisions about their care, listened to by their GP and supported by staff. All patients, apart from one, considered that GPs had enough time for consultations. Patient feedback on the comments cards that we received was predominantly positive and aligned with these views. Results from national GP patient survey, indicated that 77 patients responded to the survey in 2014 and 77% said the last GP they saw or spoke to was good at involving them in decisions about their care. This is slightly lower than the

Good

Are services caring?

national average of 81%. 83% of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care. This is slightly lower than the national average of 85%.

Over 25% of the patient population did not speak English as a first language and patients at the practice spoke a total of 42 different languages. The practice website had fact sheets available in 21 different languages. The automated check-in was available in ten different languages and a language line translation service was available. We observed a patient, who was supported to use this service.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with were positive about the emotional support provided by the practice. The practice provided care to residents at a school for people with autism. A member of staff told us that they supported patients who were anxious and that they talked to them whilst they were waiting for their appointment. Staff told us that if a patient looks very ill, they escalated this to the GP and the patient was seen immediately.

Notices in the waiting room, TV screen and information on the practice website told patients how to access support groups and organisations. For example, the practice website provided information for people with long term conditions, such as chronic obstructive pulmonary disease. This included a link to the British Lung Foundation website.

People who were on the palliative care register, were supported by two named GP's. GP's told us that they worked with patients, families and a multi-disciplinary team to provide end of life care that met the patients' needs

The practice provided funding for fifteen hours of one to one counselling each week, which was made available to those patients who would not otherwise be eligible for a counselling service through any other route.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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 that the service was delivered. For example in response to patient feedback, the practice had employed an additional two reception staff to work during identified peak times in order to improve the service provided.

Tackling inequity and promoting equality

The practices had recognised the needs of different groups when accessing its services. 25% of the patient population did not speak English as a first language and patients at the practice spoke a total of 42 different languages. The practice had information leaflets on its website in 21 languages and an automated check-in facility was available in ten different languages The practice had sign language support services and translators could be booked if sufficient notice was given. Patients could request access to a male or female GP. Staff from the practice worked with a local community radio station to provide information to patients about how to access the service. They had also provided health advice to women from the local Afghan community. A GP told us that he had met with a Somali leader to discuss how patients from the local Somali population can access the service more easily.

The premises had been adapted to meet the needs of patients with disabilities. The practice was accessible to patients with limited mobility and there was a lift to access the first floor. The waiting area was large enough to accommodate patients with wheelchairs and prams and there were access enabled toilets and baby changing facilities. This made movement around the practice easier and helped to maintain patients' independence.

Patients who were homeless accessed treatment at the location and the practice address was used as a point of contact for referral letters when needed. Patients were also directed to homeless services in the area. The practice supported patients who misused substances and reviewed them every six months with a substance misuse counsellor.

The practice paid to provide an additional 15 hours of free counselling each week, that could be accessed by patients who would not otherwise by eligible for access to counselling services.

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

Access to the service

The practice was open from 8.30am to 6.30pm Monday to Friday. Telephone lines opened at 8am on weekdays. Pre-booked appointments were available with a GP and a nurse from 7.30am on Thursdays. Additional appointments were available at Telephone House Surgery until 8pm on a Monday and Thursday and on Saturday mornings. The extended opening hours supported access for working age people (including those who are recently retired and students) and also for school age children. All patients could access appointments at two sites and routine appointments could be booked one week in advance. We saw some routine appointments were available for the following day. A staff member told us that if a patient needed an urgent appointment and there were none the reception manager would try and fit the patient in. Patients with diabetes were monitored using telephone consultations to provide updates on their well-being. This was in addition to routine checks. Patients registered at the practice that were unable to visit the surgery were offered home visits.

The appointment booking system had been revised in response to patient feedback and an increased number of appointments were available for patients to be seen on the same day. On the day of our visit three GPs were available for same day appointments and a GP was available for telephone consultations and triage. Audits of appointment where patients had not attended were completed. The percentage of patients who did not attend was lower if patients were given appointments on the same day. The increased number of appointments available to patients on the same day had led to a decrease in the number of patients who were using accident and emergency services. A GP told us that if patients knew that they could see their GP at 8.30am the next morning then they were less likely to go to the out of hours service.

Information on NHS Choices had indicated that it was sometimes difficult to book an appointment. The practice had responded to this information by providing an extra

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

four locum sessions during the winter months and had then increased this provision to an additional seven locum sessions per week in response to an increase in demand for appointments between December 2014 and March 2015. Feedback from the PPG received on 25th March 2015, indicated that whilst appointments were available, it was sometimes difficult to book appointments with a named and preferred GP.

We spoke to eight patients at the practice and all except one said that they had satisfied with the appointment system. They confirmed that they could see a doctor on the same day if they felt if it was urgent and that children were seen on the same day. One patient indicated that it was difficult to get an appointment with a named GP.

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 practice website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed through the 111 service or out of hours care through Hampshire Doctors On Call. Leaflets and posters provided information to patients about the out of hours services.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy is in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system. This information was in the practice leaflet and in a folder at the side of the reception desk. We saw that the folder was not prominently displayed and there were no notices advising patients of the complaints system. None of the patients that we spoke with had ever needed to make a complaint about the practice.

We looked at nine complaints which had been received in the last 12 months. The complaints had been dealt with in a timely manner and had been resolved as far as practicably possible to the complainants' satisfaction. The practice gave examples of how it had taken action as a result of complaints received. For example, in response to concerns that reception staff were considered to be rude, training had been provided on effective communication. We noted that one complaint related to information being provided to a third party without a patient having the opportunity to review the information before it was released. The practice had not updated their policy on sharing information to ensure that patients could be confident that information would only be shared with their full consent and this would be verified prior to information being released.

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 mission statement to deliver high quality care and promote good outcomes for patients. There was no formal plan available but consideration to forthcoming challenges had been documented. GP partners held a formal meeting at least annually to discuss strategic planning and partners had a monthly strategy meeting and a weekly business meeting.

The practice aims were displayed on the practice website. The aims included a commitment to providing and promoting excellent health care to our patients within a caring environment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice intranet site. Policies and procedures on Health and Safety, Control of Substances Hazardous to Health (COSHH) and manual handling had all been reviewed in February 2015 and were available to staff on the intranet site. However, we identified that some policies and procedures needed updating. This included policies and procedures on infection control, accident reporting and sharing information. Health and safety was discussed at weekly partners meetings and we saw minutes for these meetings

There was a clear leadership structure with named staff in lead roles responsible for key areas such as complaints, information and technology, safeguarding and prescribing. Staff we spoke with were clear about their roles and responsibilities and said that they felt supported. Staff were able to identify who they would go to in the practice with any concerns. A staff handbook was available on the intranet and this was updated in February 2013, however, not all staff had signed to indicate that they had read the handbook.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were being used consistently and effectively. This included using the Quality and Outcomes Framework (QOF) to measure its performance. The practice provided a breakdown of QOF data for the period of 2014-1015, indicating that it had met the majority of its QOF targets. QOF data was regularly discussed at team meetings.

The practice had systems in place for completing clinical audit cycles. We reviewed two clinical audits that had taken place in the last year. An audit of minor surgical procedures was completed in January 2015. This included all the types of surgery being undertaken and the audit looked at information about infection and complication rates. audit of Pregablin Prescribing had also been undertaken.

The practice identified, managed and recorded risks. A specific template had been created to record care and identify risks to patients with long-term conditions such as diabetes and chronic obstructive pulmonary disease. Safeguarding risks were shared with local authority safeguarding teams and identified risks to an unborn child, were shared with antenatal care providers. The standard examination and consultation template had been amended to highlight those who may pose a risk to themselves or others and prompted staff to ask appropriate questions.

Risk assessments were in place, including a risk assessment of the building and a fire risk assessment. The practice held regular meetings at least monthly, where governance issued were discussed. We looked at minutes of these meetings which indicated that identified risks had been discussed.

Leadership, openness and transparency

The partners in the practice were visible and staff told us that they were approachable and that they were supported by the GP partners and management.

The practice held meetings including monthly multidisciplinary board meetings, monthly nurses meetings, monthly reception meetings, quarterly special projects meetings, monthly partners' strategy meetings and weekly partners' business meetings. Staff attended team meetings on a monthly basis and that they received minutes of the meetings by e-mail if they could not attend them. Meetings were used to identify areas were improvements could be made across the practice. The practice had a diverse staff team we were told that a member of staff was supported to observe Ramadan. The practice had a family first policy around staff taking leave.

Are services well-led?

Good

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

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It gathered feedback from patients through satisfaction surveys, the friends and family test and complaints received. There was a newly formed patient participation group (PPG) and we met with a representative from the PPG..

The practice had implemented improvements and made changes to the way that it delivered services in response to patients feedback. An additional seven locum sessions per week had been added between December 2014 and March 2015 in response to feedback that patients were finding it difficult to access appointments and the practice had recruited two new reception staff to work during peak times.

Management lead through learning and improvement

Staff were supported to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. GP appraisals contained feedback on their performance from other staff. Reception staff told us that they had received training in supporting patients who had been involved in domestic violence and training in communication. The practice was last accredited as a GP training practice on 2 September 2013.

The practice had completed reviews of significant events and other incidents and shared learning with relevant staff at meetings to ensure the practice improved outcomes for patients. We looked at the management of 22 significant events that had occurred since April 2014. We reviewed an incident where a child had a high temperature and the GP had not done a urine test. The process for dealing with febrile children had been updated as a result of this incident. This protocol was shared across the clinical commissioning group.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (d).ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; Regulation: 12 How the regulation was not being met: There was a fire door that had been bolted and there could not be used for it's intended purpose to provide an means of egress in an emergency.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13. Service users must be protected from abuse and improper treatment in accordance with this regulation. How the regulation was not being met. Regulation 13 How the regulation was not being met: Nurses , healthcare assistants and reception staff who were undertaking chaperone duties did not have a check via the Disclosure and Barring Service. There was no risk assessment in place for those staff who did not have a DBS check but who chaperone patients.