# Statham Grove Surgery

## Quality Report

Statham Grove
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Date of inspection visit: 25 February 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? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| 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 Statham Grove Surgery on 25 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and well-led services. The practice required improvement for providing safe services. It was also good for providing services for older people, people with long term-conditions, families, children and young people, the 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, with the exception of those relating to storing medicines.
- 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 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.

# Summary of findings

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

Importantly the provider must:

- Ensure the secure storage of GP home visit bags.

Action the provider SHOULD take to improve:

- Maintain cleaning schedules to evidence the cleaning of the patient toilet and toys for children at the practice.
- Keep a register for vulnerable adults.

**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 their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Significant events were discussed routinely at both clinical and practice meetings.

Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example there were concerns regarding the storage GP home visit bags, which did not prevent unauthorised access.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff were committed to working collaboratively and people who had complex needs were supported to receive coordinated care. There were efficient ways to deliver more joined up care to patients. These included assessing mental capacity and promoting good health. The continuing development of staff skills, competence and knowledge were recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice. We found staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff appraisals and personal development plans were in place for all staff.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual physical health check. Similar mechanisms for identifying 'at risk' groups were used for patients who were carers, obese, experiencing mental ill health and those receiving end of life care. These groups were offered further support in line with their needs and were offered advice on support networks.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and

# Summary of findings

they were involved in decisions about their care and treatment. The data from the GP Patient Survey 2014 told us patients had confidence in the clinical staff they saw. The majority of patients said they had confidence and trust in the last GP they saw or spoke to and said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with most stating the GP was good at listening to them. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness, respect and maintained confidentiality.

The practice offered patients information as to what to do in time of bereavement and also referred them to a local counselling service. A patient we spoke with confirmed they were referred and had used this service. The practice also had an external support service which was funded by the local Clinical Commissioning Group (CCG) to provide additional social support services to patients.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations.

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

Good

The practice is rated as good for providing responsive services. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice responded quickly to issues raised and learned from 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. The practice manager was the designated responsible person who handled all complaints in the practice. Patients were also provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

**Are services well-led?**

Good

The practice is rated as good for being well-led.The practice had a clear vision to deliver high quality care and promote good outcomes for patients. All staff were aware of the practice's vision and understood what their responsibilities were in relation to providing a good quality service. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought

# Summary of findings

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| feedback from staff and patients. The patient participation group (PPG) was established and feedback from the group was always acted on. 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. Older people were cared for with dignity and respect. The practice was responsive to their needs, and there was evidence of working with other health and social care providers to provide safe care. We found that older patients identified at risk of isolation were discussed at monthly clinical meetings as well as multi-disciplinary meetings to monitor their care and address the support they required as necessary. The practice had 212 patients over 75 years old and 48 patients on the Avoiding Unplanned Admissions List which is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. All of these patients had a named GP.

Home visits were also made to older patients. There was evidence of learning and sharing of information to help improve care delivery. There were structured and meaningful discussions in meetings to resolve issues in a time-bound and effective manner.

### People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. There was evidence of effective and responsive care to patients with long term conditions (LTCs). Clinical staff had the knowledge and skills to respond to the needs of patients with cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD).

There was a palliative care (end of life) register and patients on the register were discussed at the monthly palliative care meetings. Patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. Longer appointments were also available for people who needed them, for example patients with long-term conditions.

### Families, children and young people

Good

The practice is rated as good for care of families, children and young people. The practice was responsive to the needs of this group. There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. GPs were appropriately using the required codes on their

# Summary of findings

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. Records demonstrated good liaison with partner agencies such as the police and social services. Clinical staff attended child protection case conferences and reviews where appropriate. The practice offered a full range of immunisations for children, which included travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. Appointments were made available outside of school hours for children and young people and we saw that premises were suitable for children and young people.

**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). There were a variety of appointment options available to patients such as telephone consultations, on-line booking and extended hours. The practice was performing well in undertaking cervical smear examinations and performance for cervical smear uptake was higher than other practices in the CCG area. Patients who did not attend for cervical smears were followed up and the uptake for health and blood pressure checks for working age patients was high.

**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. Patients attending the practice were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing. Staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

The practice had numerous ways of identifying patients who needed additional support. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice website offered patients information as to what to do in time of bereavement and referral arrangements were in place with a local counselling service.

# Summary of findings

Notices in the patient waiting room, 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 told carers could also access support service available at the practice.

**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). The practice provided a caring and responsive service to people experiencing poor mental health.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice worked closely with the local mental health team and held eight meetings a year with them to promote and plan services for patients with poor mental health, and we saw meeting minutes to confirm they took place. The practice offered a primary care psychotherapy consultation service and had a named psychotherapist attached to the practice, offering specialist input to patients experiencing poor mental health.

All clinical staff had received training in the Mental Capacity Act 2005 and were able to demonstrate an understanding of key parts of the legislation and describe how they implemented it in their practice.

# Summary of findings

## What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014 and a survey of 250 patients undertaken by the practice in 2014. These highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 107 patients who completed the survey, 99% said they had confidence and trust in the last GP they saw or spoke with and 100% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with 99% of practice respondents saying the GP was good at listening to them, describing their experience as very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards and all had made positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Nine comments cards included negative comments, three related to the cleanliness of the patient toilet, a further three highlighted they did not always find it easy to get through on the phone and the remaining three comments identified historical problems with reception staff but did record that they had seen a noticeable improvement recently.

## Areas for improvement

**Action the service MUST take to improve**

- Ensure the secure storage of medication and GP home visit bags.

**Action the service SHOULD take to improve**

- Maintain cleaning schedules to evidence the cleaning of the patient toilet and toys for children at the practice.
- Keep a register for vulnerable adults.

# Statham Grove Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

## Background to Statham Grove Surgery

Statham Grove Surgery is situated in Stoke Newington in London and belongs to NHS City and Hackney Clinical Commissioning Group. The practice holds a GMS contract (General Medical Services agreements are locally agreed contracts between NHS England and a GP practice) and provided a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinics, and contraception services.

The practice is registered with the Care Quality Commission to carry on the regulated activities of Maternity and midwifery services, Diagnostic and screening procedures, Family planning, Surgical procedures, and Treatment of disease, disorder or injury.

The practice had a patient list of just over 8000 at the time of our inspection. The staff team at the practice included five partner GPs and two salaried GPs, compromising two male and five female GPs (all working a mix of full time and part time hours). In addition to this there were four GP trainees, two practice nurses and one healthcare assistant, a practice manager and a team of administrative staff. Statham Grove is an approved training practice for GP Registrars.

The practice is open between 08:00 and 18:30 Monday to Friday. Appointments are from 9:00 to 12:00 every morning and 16:00 to 19:00 daily. Extended hours surgeries are offered on Monday, Tuesday and Thursday until 19.30. To assist patients in accessing the service there was an easy to use online booking system, text message reminders for appointments and test results. Urgent appointments were available each day and GPs also completed telephone consultations for patients. The out of hours services were provided by a local deputising service to cover the practice when it was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

The practice had a lower percentage (than the national average) of people with a long standing health condition (38.2% compared to 54.0%); and a lower percentage (than the national average) of people with health related problems in daily life (44.3% compared to 48.8%). The average male and female life expectancy for the Clinical Commissioning Group area was above that of the national average.

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.

## Why we carried out this inspection

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

# Detailed findings

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

## 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 we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 February 2015. During our visit we spoke with a range of staff such as three of the GP partners, practice nurses, healthcare assistant, practice manager and administrative staff. We spoke with 13 patients. We reviewed personal care or treatment records of patients.

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety including reported incidents, national patient safety alerts, 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. The practice manager told us that significant events were discussed in meetings and we saw minutes to confirm this. For example, we saw one recorded significant event where a patient's clinical notes had an incorrect medical entry recorded, placing them at risk of inappropriate Warfarin prescribing. The patient did not make a complaint but a significant event analysis was carried out and apologies made. The issue was identified as being caused by incorrect use of the practice computer system and further instructions were sent to all clinical staff informing them on how to use the system correctly when switching between patients.

We reviewed safety records, incident reports and minutes of meetings for the last two years. This showed the practice had managed these consistently and showed 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. There were records of significant events and we were provided with a log dating from March 2014 to the present date. Recorded in the log was a brief outline of the event and the learning outcomes. For example, one entry related to a patient becoming unwell when arriving at the practice but was added to one of the GP's evening surgery list instead of being seen as an emergency. The patient became distressed and in severe pain and was observed by one of the GPs and two GP registrars who saw the patient in the waiting area. The patient was immediately seen and admitted to hospital. The event was discussed with staff and the availability of injectable analgesia and protocol for emergencies in reception was reviewed.

Significant events were a standing item on the agendas for both clinical meetings which took place weekly and non-clinical monthly practice meetings, including all clinical and non-clinical staff to review actions from past significant events and complaints. The practice had been open and honest when dealing with and recording such events and every effort was made to learn from them. 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.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to all practice staff as well as by email to all clinicians. We were shown the protocol which was very thorough. Staff we spoke with were able to give examples of recent alerts. For example we saw recent alerts from The Medicines and Healthcare products Regulatory Agency (MHRA) which had been distributed relating to the prescribing of domperidone, amlodipine and statins. Alerts were also discussed at monthly practice meetings to ensure all staff were aware of any that were relevant to their practice and where they needed to take action. We saw minutes of staff meetings which evidenced this.

### 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 all staff had received relevant role specific training on safeguarding. Two GP partners each took a lead on safeguarding adults and children within the practice. All staff we spoke to were aware who these leads were and who to speak to if they had a safeguarding concern. 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 knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff on the shared computer system and displayed in staff offices.

All GPs and both practice nurses had been trained to Level three in child protection and all other non-clinical staff to Level one. They demonstrated they had the necessary training to enable them to fulfil this role. The practice had a register for vulnerable children but not vulnerable adults.

Requires improvement

# Are services safe?

The child protection register was updated monthly by the GP lead in safeguarding and reviewed with the health visitor on a monthly basis. Vulnerable patients were discussed routinely at clinical meetings.

GPs and the practice nurse were appropriately using the required codes on their electronic case management systems to ensure risks to children and young people who were looked after and on child protection plans were clearly flagged and reviewed. Clinical staff attended children protection case conferences and reviews where appropriate, with the last attendance in September 2014. Reports were sent if they were unable to attend and scanned into the patient's medical records. The records demonstrated good liaison with partner agencies such as the police and social services.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. One of the practice nurses had been trained to chaperone and some reception staff were also in the process of being training. The trained member of staff we spoke with understood their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination. The member of staff had a completed Disclosure and Barring Service (DBS) check, which enabled employers to check the criminal records of employees.

## Medicines management

We checked medicines stored in the medicine refrigerators. Fridge temperatures were taken each day and an audit trail was kept. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Medications were stored in locked cupboards and fridges in a separate room. However, we found the door was kept open and unlocked to this room. This was immediately discussed with clinical staff and the room door was closed and locked.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines were checked monthly and an audit trail was maintained. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of appropriately. However, on checking the GP's bags for home visits which included prescription pads and basic emergency care medications, we found they were kept in an open treatment room which was not kept locked. This did not ensure the safe storage of GP home visit bags and the medication and prescription pads within them.

The two practice nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the practice nurse and the health care assistant had received appropriate training to administer vaccines, for example clinical immunisations and vaccines updates.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example, we checked five anonymised patient records which confirmed that the procedure was being followed. We saw the practice protocol and annual recall spread sheet for patients on high risk medicines. The practice had conducted an audit of patients receiving opiates in October and November 2014. As a result the prescribing of opiates was reviewed. The practice's performance for antibiotic prescribing was comparable to the CCG average (0.052 compared to 0.056).

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice also issued prescriptions through their online system which were directly sent to the patient's specified pharmacy. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and were kept securely at all times in a secure cupboard.

## Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Disposable curtains were in place in each treatment room and were replaced every six months.

One of the practice nurses was the lead for infection control and had undertaken training to enable them to provide advice on the practice infection control policy and deliver staff training. All staff received induction training about infection control specific to their role and received annual

updates. Updates were also discussed at practices meetings and we saw the minutes of these meetings confirming this. The practice had carried out infection control audits for the last three years.

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. Sharp bins were correctly assembled and dated, and staff disposed of clinical waste appropriately. The practice had lockable wheeled waste bins in the car park and a waste management collection contract in place.

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

The practice had completed a legionella test on a yearly basis to reduce the risk of infection to staff and patients. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Cleaning of the practice was completed everyday by an external cleaning contractor. Some weekly cleaning schedules were in place for the cleaning of the practice and written records were kept of this. The infection control code of practice for the external cleaning contractor was provided to us but we did not see cleaning schedules for the patient toilets and toys for children at the practice. Three comments on CQC comment cards had also highlighted concerns with the cleanliness of the patient toilet.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw evidence of calibration of relevant equipment completed on an annual basis such as the vaccine fridge, spirometer, weighing scales, defibrillator and blood pressure devices.

### 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, two files for reception staff, two practice nurses and the practice manager, we looked at, had proof of identification, references and qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) which enabled employers to check the criminal records of employees.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. They 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 were in line with planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Priority was given to provide cover in house however as a contingency the practice kept a locum GP contact list.

### 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. There were checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Annual audits were also completed for new medicines, and waste management. Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within practice meetings. The practice had a health and safety policy. Health and safety information was displayed around the practice and the practice manager was the identified health and safety representative.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

Requires improvement

# Are services safe?

## 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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of the equipment and records confirmed that it was checked regularly.

Emergency medicines were available 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. Monthly and annual processes were 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 impacted 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 informed staff of what to do and who to contact if they experienced loss of the computer system, telephones, electricity or water.

The practice carried out an annual fire risk assessment to maintain fire safety and had a designated fire marshal responsible for monthly checks of all fire equipment. All fire equipment such as the fire alarm was serviced yearly and the staff team practised weekly fire drills.

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 and from local commissioners. We saw minutes of practice and clinical meetings where new guidelines were disseminated, the implications of it for the practice's performance considered, patients were discussed and the required actions agreed. For example, discussions at clinical meetings confirmed that assessments were designed to ensure that each patient received support to achieve the best health outcomes for them. In addition there was an education cascade generated at each meeting.

The practice had 212 patients over 75 years old and 48 patients on the Avoiding Unplanned Admissions List which is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. All these patients had a named GP. A register was kept of patients who were in need of regular home visits which included 40 patients and they had all received an annual health review. We randomly selected one care record for review for a patient who fell under this criteria. The record contained patient information and carer details, a care plan which was detailed and reflected the health care needs of the patient. The care plan was last reviewed in November 2014.

The GPs told us they lead in specialist clinical areas such as safeguarding, medication prescribing, long term conditions, palliative care, training and the practice had one of the GP's as the Clinical Commissioning lead and who was also a non-board member of the group. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes and staff training records confirmed this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

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 to support the practice to carry out clinical audits.

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) which is a national performance measurement tool. The practice showed us 12 clinical audits that had been undertaken in the last two years. Three of these were completed audits which were on the monitoring of disease modifying antirheumatic drugs (DMARDs), the rational use of high dose inhaled corticosteroids in asthma and chronic obstructive pulmonary disease (COPD) and opiate prescribing. The practice was able to demonstrate the changes they made since the completed audits cycles. For example, the first cycle of looking at DMARDs was completed in June 2013 and the second cycle was completed in January 2014. The audit highlighted areas for improvement particularly the low number of patients entered on high risk drugs templates and a low number of patients on DMARDs being appropriately counselled, especially patients who had been on these medications for many years. The second completed cycle recorded improvements and highlighted

Good

# Are services effective?

## (for example, treatment is effective)

an increase in the number of patients on DMARDs who had been entered onto the high risk drugs template, which increased from 12% to 79% and the number of patients receiving appropriate counselling increasing from 9% to 67%.

The second completed audit reviewed the prescribing of inhaled corticosteroids (ICS) for patients with asthma and COPD with the aim to review prescribing of ICS, to reduce the dose of ICS where clinically appropriate in asthma patients and ensure ICS were prescribed in line with NICE guidelines for patients with COPD. The first cycle was in August 2014 and completed in March 2015. Following cycle two, the audit noted an improvement in reducing the rate of patients on high dose ICS, from 36% to 73%.

Following the completed audit on monitoring opiate prescribing it was confirmed that good levels of correct controlled drugs prescribing were in place and that there needed to be continuous improvement in documentation of opiate use. Other incomplete audits looked at medicine waste, repeat prescribing, anticoagulation, APEL atrial fibrillation, planned care audit and first op referrals, frail home visiting and a review of outpatient referrals.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example the practice met all the minimum standards for QOF in asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypothyroidism, osteoporosis, palliative care, rheumatoid arthritis and stroke. It achieved most of the standards for diabetes (achieving 97.84 out of 107 points) and hypertension (74.64 out of 77 points).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. We looked at the medical records for two diabetic patients and found appropriate medication had been reviewed and prescribed. The IT system flagged up relevant medicine alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The practice also participated to a degree 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. For example the local CCG provided a lot of data and feedback to local practices and a CCG wide network incorporating this feedback and a lot of other aspects such as policies was in place.

### Effective staffing

Practice staff included five partner GPs, two salaried GPs, four GP trainees, two practice nurses and one healthcare assistant, a practice manager and a team of administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory training courses such as annual basic life support, safeguarding adults and chaperoning. We noted a good skill mix among the GPs with one GP having additional diplomas in management of drug misuse, mountain medicine, management in alcohol problems in primary care and another GP has a diploma in dermatology. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees.

All GPs were up to date with their yearly continuing professional development requirements and one had been revalidated in January 2015 and six GPs were due their revalidation in 2015. This is a process where 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.

Good

# Are services effective?

## (for example, treatment is effective)

We reviewed four staff files, which confirmed this. Our discussions with clinical staff confirmed that the practice was proactive in providing training and funding for relevant courses, such as cytology, contraceptive and sexual health updates, COPD training, wound management, tissue viability, learning disability, immunisation skills and ear care which the practice nurses had attended.

### Working with colleagues and other services

The practice 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 from communications with other care providers on the day they were received. The GPs who saw these documents and results, were responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice worked with other service providers to meet patient needs and manage complex cases. It held clinical multidisciplinary team meetings once a month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, community matron and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### Information sharing

The practice used several electronic systems to communicate with other providers. 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. Electronic systems were also in place for making referrals; the practice used the Choose and Book system, which enabled patients to choose which hospital they would like to be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident & Emergency (A&E) department. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems to provide staff with the information they needed. Staff used electronic patient records to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this legislation. All clinical staff had received training in the Mental Capacity Act 2005. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. These processes highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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 contained a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us five care plans that had been reviewed in the last year. In total, there were 22 patients diagnosed with dementia and 86% had received a review. 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 Gillick competencies. These helped clinicians to identify children aged under 16 who had the legal capacity to consent to medical examinations and treatment.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

### Health promotion and prevention

The practice had met with the Public Health team from the Clinical Commissioning Group to discuss the implications

Good

# Are services effective?

## (for example, treatment is effective)

of and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected 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 had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and had 27 patients on the register who were all offered an annual physical health check. The practice had a palliative care register of 5 patients and had monthly internal as well as external multidisciplinary meetings to discuss the care and support needs of patients and their families.

Out of 2061 patients over the age of 45 years who required a blood pressure check, 90% had been seen and out of 2287 patients who required a smear test in the last five years, 83% had been seen, which was 5.2% higher than the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice was on target for annual medication reviews for patients with diabetes and had seen 75% of its patients. Patients were given support to stop smoking and QOF data showed us that out of 1117 patients 57% were given support. There were 412 patients on the asthma register and 84% of those patients had a medication review. The practice met all the minimum standards for QOF in diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD). The practice performance was 2.7% above the CCG average. Similar mechanisms of identifying 'at risk' groups were used for patients who were identified as carers, were obese, those receiving end of life care and those who experienced poor mental health. These groups were offered further support in line with their needs and offered advice on support networks.

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 for all childhood immunisations was above average for the CCG, for example 92.2% of children aged 24 months had received an MMR vaccination compared to the CCG average of 89.7%; 88.5% of 5 year old children had received the Dtap/IPV Booster compared to the CCG average of 77.2%.

The practice also offered a baby clinic, at which a health visitor was available to give advice; clinics for maternity, family planning and a Turkish children's clinic for Turkish speaking parents. There was a sexual health service including the fitting of coils and implants and occupational health and travel services. Patients were able to access a range of information via the practice website. This included guidance on long term conditions such as asthma, heart disease, diabetes; epilepsy, hypertension, respiratory disease, family health and minor illnesses.

The practice supported its students and working age patients by offering extended opening hours, telephone appointments and online bookings.

Data from QOF indicated the practice exceeded the national average for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 96% compared to the national average of 86%. It also exceeded the national average for the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months, achieving 100% compared to the national average of 83.8%.

The practice registered patients who were homeless and held monthly meetings with a consultant psychiatrist and primary care psychologist to discuss all patients on their register experiencing poor mental health, which we saw meeting minutes of. There were 95 patients on the register and 90% had an agreed care plan in place.

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 GP Patient Survey 2014 and a survey of 250 patients undertaken by the practice in 2014. These highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 107 patients who completed the survey, 99% said they had confidence and trust in the last GP they saw or spoke with and 100% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with 99% practice respondents saying the GP was good at listening to them, describing their experience as very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards and all had made positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Nine comments cards included negative comments, three related to the cleanliness of the patient toilet, a further three highlighted they did not always find it easy to get through on the phone and the remaining three comments identified historical problems with reception staff but did record that they had seen a noticeable improvement recently.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped patient information to be kept private. Patients could speak to reception staff in a private room and notices were displayed in the reception areas informing patients of this option.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would conduct an investigation and any learning identified would be shared with staff.

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. Panic alarms were situated behind the reception desk and in each treatment room for staff to use in the event of an emergency.

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

The GP Patient Survey 2014 and comment cards we received showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the GP Patient Survey showed 95% of respondents said the GP involved them in care decisions and 98% of patients felt the GP was good at explaining treatments.

Four patients we spoke to on the day of our inspection who were also members of the Patient Participation Group (PPG), 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 CQC comment cards was also aligned with these views.

Staff told us 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. Sign language services were available to support patients with a hearing disability. The practice also had an external support service which was funded by the local Clinical Commissioning Group (CCG) to provide additional social support services to patients. The

Good

# Are services caring?

support group visited the practice once a week and provided services to patients which included counselling, financial advice, support to patients experiencing domestic violence, poor mental health, isolation, depression or in vulnerable circumstances. We spoke to a representative of the group during our inspection who informed us how well received the service had been by patients and that it reduced the work load for GPs in that they could concentrate on addressing clinical concerns rather than social issues which the service addressed.

We saw evidence of care planning and patient involvement for adults at risk of an emergency admission. A case management register was also kept of all children who had an unplanned admission to the accident and emergency department or the OOH services, to ensure they had a follow up consultation. The practice told us they used the Department of Health's 'You're Welcome' criteria to provide young people friendly health services.

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

The practice website offered patients information as to what to do in time of bereavement and also referred them to a local counselling service. A patient we spoke with confirmed they were referred and had used this service.

Notices in the patient waiting room advised patients how to access a number of support groups and organisations. The practice computer system alerted GPs if a patient was also a carer and the practice assessed carers' needs and kept a register of these individuals.

We saw that older patients identified as at risk of isolation were discussed at clinical meetings as well as to address the support they required.

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 patient's 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.

We were informed that there was close liaison between the practice and the CCG, particularly as one of the practice partners was a non-board member of the CCG. There was documented evidence to evidence how discussions with the CCG had led the practice to implement service improvements or manage delivery challenges to its population.

We found the practice to be involved in actively promoting its Patient Participation Group (PPG) which had been meeting for the last two years and included 30 members. The group met on a quarterly basis. The practice website and posters in the reception area were advertising for more patients to join and gave them information on what was involved, as the group informed us that their current composition did not reflect the local community in terms of ethnicity and age. We spoke with four members of the PPG who said they were very happy with the efforts the practice had taken to involve patients in their care. They felt that their concerns were listened to and suggestions were always implemented and they had achieved some marked improvements at the practice. For example, they informed they had seen improvements in the service offered by reception staff and had been able to obtain a dedicated notice board for patients in the waiting area, after the issues were discussed within the PPG.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We saw the practice had identified the numbers of patients on the learning disability register, those experiencing poor mental health, patients who were carers, children and adults on the vulnerable risk register and patients with dementia. There was a palliative care register and the practice had regular monthly palliative care meetings to discuss patients, their families care and support needs. The needs of these different groups were discussed at the range of meetings that took place at the practice with internal and external clinical staff.

The practice had not provided equality and diversity training to its staff team. Although, this training had not been provided, equality and diversity was regularly discussed at staff appraisals and practice team meetings.

The premises and services had been adapted to meet the needs of people with disabilities and there was

pram and wheelchair access throughout the premises. As well as an accessible toilet there were also baby changing facilities. The practice was situated on the ground floor with all services for patients operating from this floor.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice worked closely with the local mental health team and held eight meetings a year with the team to promote and plan services for patients with poor mental health, and we saw meeting minutes to confirm they took place. The practice offered a primary care psychotherapy consultation[CS1] service and had a named allocated psychotherapist to the practice, offering specialist input to mentally ill patients. In the event of a patient experiencing a mental health crisis they were directed to the accident and emergency department or to the community mental health team.

### Access to the service

The practice was open between 08:00 and 18:30 Monday to Friday. Appointments were from 9:00 to 12:00 every morning and 16:00 to 19:00 daily. Extended hours surgeries were offered on Monday, Tuesday and Thursday until 19.30. To assist patients in accessing the service there was an easy to use online booking system, text message reminders for appointments and test results. Urgent appointments were available each day and GPs also completed telephone consultations for patients. The out of hours services were provided by a local deputising service to cover the practice when it was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

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 their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

Longer appointments were available with a named GP, nurse or healthcare assistant for people who needed them, for example those with long-term conditions. Home visits were made to those patients who needed one, such as older patients and those with long term conditions.

The GP Patient Survey 2014 had 82% of patients who described their experience of making an appointment as good and 90% said they find it easy to get through to the surgery by phone.

### 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. The practice manager was the designated responsible person who handled all complaints in the practice. Patients were also provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

We saw that information was available to help patients understand the complaints system such as posters displayed in the reception area. Four members of the PPG we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had recorded 10 complaints between March 2014 and January 2015. They were satisfactorily handled and were dealt with in a timely way which was in accordance with the practice's complaints policy. Each complainant was written to, discussing their complaint in detail and were invited to see the practice manager with an aim to resolve their complaint. All complaints were thoroughly recorded and we saw evidence of openness and transparency when dealing with complaints. All verbal complaints were recorded in writing to ensure they were not missed and were also responded to in writing.

The practice reviewed complaints on an on-going basis and in 2014 had completed five reviews to detect themes and trends. As a result of the last review in 2014 it was highlighted that it was difficult to make appointments and reception staff need to be more welcoming. The issues were discussed with the PPG and a review of the appointment system and reception services was initiated. Complaints were discussed at clinical and practice team meetings to ensure lessons were learned from individual complaints. We saw from the minutes that complaints were routinely discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

# 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 manager informed us they had a vision which was also on the practice website. These values included providing high quality care for the patient population; providing a facility to meet the needs of the patients; to integrate with the community and to be a leading practice with innovative ideas. We spoke with members of staff and they all knew and understood their responsibilities were in relation to providing a good quality service. They were aware of the needs of the local population and how the practice was meeting its needs.

### 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 and were also given to staff in the form of a handbook. We reviewed a number of policies, for example the induction policy and recruitment policy, which were in place to support staff. They were detailed and provided appropriate guidance for staff. We were shown the staff handbook that was available to all staff, which included sections on equality, harassment and bullying at work. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control, safeguarding, medication management audits, health and safety, fire safety, information governance and patient complaints. We spoke with eight members of staff who told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff were encouraged to learn and develop their careers.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. This was reflected in the meeting minutes we reviewed.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice showed us 12 clinical audits that had been undertaken in the last two years. Three of these were completed audits which were on monitoring of disease modifying anti-rheumatic drugs (DMARDs), the rational use of high dose inhaled corticosteroids in asthma and chronic obstructive pulmonary disease (COPD) and opiate prescribing. The practice was able to demonstrate the changes they made since the completed audits cycles. The GPs told us clinical audits were often linked to medicines management information and safety alerts.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as risks to the building, staff, dealing with emergencies and equipment. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at GP partners' meetings and within team meetings.

The practice also had a health and safety policy. Health and safety information was displayed in the staff room for staff to see and the practice manager was the identified health and safety representative.

The practice held monthly practice meetings which discussed governance. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

### Leadership, openness and transparency

We saw from meeting minutes that team meetings were held monthly and clinical meetings on a weekly basis. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings.

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

The practice had gathered feedback from patients through its practice patient surveys and complaints received. We found the practice to be involved in actively promoting its Patient Participation Group (PPG) which had been meeting for the last two years and included 30 members. We spoke with four members of the PPG who said they were very happy with the efforts the practice had taken to involve patients in their care. They had achieved some marked

# Are services well-led?

Good

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

improvements at the practice. For example, they informed they had seen improvements in the service offered by reception staff and had been able to obtain a dedicated notice board for patients in the waiting area, after the issues were discussed within the PPG.

The practice had 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. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

### Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included a personal development plan for staff. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the clinical and practice meeting agenda to review actions from past significant events and complaints. There was evidence that the practice 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. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met: The registered person had not ensured that there was the proper and safe management of medicines. GP home visit bags were not stored securely at the practice, which increased the risk of unauthorised access. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |