The Lawson Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection 11 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the six population groups - Older people, People with long-term conditions, Families, children and young people, Working age people (including those recently retired and students), People whose circumstances may make them vulnerable and People experiencing poor mental health (including people with dementia)

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- 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.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they generally found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy

Summary of findings

to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 feedback from staff and patients, which it acted on. The patient participation group was active. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff had received inductions, appropriate training, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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).

Summary of findings

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability, with 18 of the 29 patients eligible having been seen and had plans in place for the remainder to be seen before April 2015. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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

Annual physical health checks had been carried out for 59% of the eligible 170 patients. The practice was looking at ways of improving

Summary of findings

the uptake of health checks in this patient group, including offering opportunistic checks, for instance when patients attended for repeat prescriptions, and by contacting patients by phone to arrange the checks.	

Summary of findings

What people who use the service say

We spoke with eight patients and three members of the practice's Patient Participation Group. We reviewed 27 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. We looked at information published on the NHS Choices website and the 2014 National Patient Survey results, being the latest available at the date of the inspection.

The evidence from all these sources showed that patients were happy with the service provided in terms of the practice being caring. They said they were treated with dignity and respect, that the practice involved and supported them in decision making. Most spoke very highly of the GPs.

A number of patients had recorded their concerns over the practice's appointments system and problems getting through by phone. However, patients recognised that the practice had been responsive to their comments and complaints and it had sought to improve the service.

The Lawson Practice

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, practice manager, practice nurse and an Expert by Experience. An Expert by Experience is a member of the public with particular experience of using GP services.

Background to The Lawson Practice

The Lawson Practice operates from purpose built premises at St Leonards, 85 Nuttall Street, London N1 5HZ

The practice provided NHS primary medical services through a General Medical Services (GMS) contract to approximately 13,000 patients in Shoreditch, north-east London. The practice is part of the NHS City and Hackney Clinical Commissioning Group (CCG) which is made up of 43 general practices.

The practice is registered with the CQC to provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The clinical staff at the practice was made up of 14 GPs, of whom 11 were female and three male, a nurse practitioner, a nurse and three health care assistants. Five of the GPs were partners. It is a training practice and at the time of the inspection there was one registrar (trainee doctor) working there. In addition, there was a practice manager and an administrative team of 16.

The practice reception and surgery opening hours were 8.00am to 8.00pm on Monday and Wednesday; 8.00am to 7.00pm on Thursday and 8.00am to 6.30pm on Tuesday and Friday. It was closed at weekends. The practice had opted out of providing out-of-hours (OOH) services to patients and referred callers to the local OOH provider when the practice was closed.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme, carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS Choices website and the National Patient Survey and asked other organisations such as Healthwatch, NHS England and the NHS City and Hackney Clinical Commissioning Group (CCG) to share what they knew about the service. We carried out announced visit on 11 February 2015.

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?

Detailed findings

- 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)

During our visit we spoke with a range of staff including GPs, the nurse and non-clinical staff. We spoke with eight patients, and three members of the practice's Patient Participation Group. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 27 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service.

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. QOF is a national performance measurement tool, which is used to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, 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, we saw that an incident, when a visitor appeared to be drunk, was appropriately recorded in the practice incident book and investigated and addressed by the practice manager.

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 this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 15 significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. Annual meetings were held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

An incident book was used to record incidents The practice manager showed us how these were managed and monitored. We tracked 4 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, the vaccines management policy had been reviewed and discussed with reception staff, following an incident when vaccines had been delivered but were left out of a fridge and consequently needed to be disposed of. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated to practice staff using the practice's computer system. Some were passed on to staff by the practice manager, others came externally. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for instance the recall of autopen insulin injectors. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Clinical staff had all been trained to level 3 and non-clinical staff to level 1. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. Contact details for relevant safeguarding agencies were available in all the consultation rooms and in the reception area. The receptionists at the practice had worked there for many years and knew many of the patients well.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Staff demonstrated the system for us. There was active engagement in local safeguarding procedures and effective working with other relevant

organisations. We saw minutes of child protection conferences attended by practice staff and reports provided to conferences when staff had not been able to attend.

There was a chaperone policy, which was visible on the waiting room television screen, but not in the consulting rooms or on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff, including health care assistants and all but one of the receptionists, had been trained to be a chaperone. Reception staff would act as a chaperone if clinical staff were not available. One newly appointed receptionist was not being used as a chaperone until they had received the training. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. The practice used an electronic system to proactively identify and monitor if children or vulnerable adults attended accident and emergency (A&E) or missed appointments frequently. These were brought to the GPs' attention, who then worked with other health and social care professionals. For example, the practice sent recall letters to carers of children who had not attended for immunisations and if the child did not attend after that, the practice informed the health visitor. Patients who twice failed to attend for a chronic disease review were contacted by phone. We saw minutes of meetings where vulnerable patients were discussed. The practice had also carried out an audit of patients who were experiencing poor mental health attending A&E. This was to assist in reviewing service provision for patients on its severe mental illness register and to identity where improvement could be made.

Medicines management

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

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that there was a monthly check done of all medicines kept at the practice. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. No controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were kept at the practice.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescribing patterns were monitored by the practice and the City and Hackney CCG and showed no cause for concern. We saw that three audits relating to prescribing in the last 12 months, the results of which showed effective prescribing practice.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked 15 patient records which confirmed that the procedure was being followed.

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

Good

Are services safe?

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw up to date sets of PGDs in place for childhood and travel vaccines. Vaccines and other medicines were administered using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistants had received appropriate training and been assessed as competent to administer the medicines referred to, either under a PGD for nurses, or for health care assistants in accordance with a PSD from the prescriber.

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

Patients were able to order repeat prescriptions by attending in person, by post or email, or via the practice website if they had registered previously for the Patient Access service.

Cleanliness and infection control

The practice operated from purpose built premises, and had 18 consultation rooms, two treatment rooms, two minor surgery rooms and two counselling rooms. We observed the premises to be clean and tidy. We saw there were comprehensive cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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

The nurse practitioner was the infection control lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We were told that all staff received induction training about infection control specific to their role and received annual updates. The practice subsequently provided evidence to confirm the update training had been provided to all staff.

We saw evidence that the practice carried out regular infection control audits, the most recent having been done by a contractor in June 2014. Issues identified by the audits had been appropriately addressed and actions were completed on time. For example, following an infection control audit in 2012, the then Primary Care Trust had worked with the practice in designing and implementing system for decontaminating and sterilising instruments. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice had a contract in place for the removal of clinical waste. A waste management audit had been conducted in January 2014, with the results being reviewed at a clinical meeting.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. An assessment and analysis had been carried out in June 2014, showing no cause for concern.

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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in January 2015. A schedule of testing was in place. We saw evidence of the annual testing and calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The latest round of testing was on-going at the time of the inspection. Some of the equipment had been checked on the 2 February 2015 and we saw that two further dates were scheduled for testing the remainder of the equipment.

Good

Are services safe?

The practice used some reusable instruments which were appropriately cleaned and sterilised after use. The sterilising equipment was tested daily and we saw the testing record strips which confirmed this. Sterilised instruments were appropriately pouched and stored with a record of the date of sterilisation and use by date.

Staffing and recruitment

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

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We were told that it had recently been decided to recruit a deputy practice manager to provide support to the practice manager. We were shown records to demonstrate there were regular reviews of staffing levels and skills mix and that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and at team meetings.

Staff we spoke with told us how they might identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- There were emergency processes in place for patients with long-term conditions. Staff gave us an example of a referral made for a patient whose health deteriorated suddenly, including informing the relevant team at a local hospital, the community matron and district nursing team.
- There were emergency processes in place for identifying acutely ill children and young people. Staff told us of an example of a referral made when a child attending the practice had suspected appendicitis. The staff member immediate spoke with one of the GPs and the child was taken to A&E by ambulance.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. It was the practice's policy to ensure that training in basic life support was provided to clinical staff every 18 months and to non-clinical staff every three years. Record showed that training had been provided to all staff in October 2014. Emergency equipment was available including access to oxygen and a recently obtained automated external defibrillator (used in cardiac emergencies). Staff knew the location of this equipment and had been trained in its use. Records showed the equipped was checked weekly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. A chart showing appropriate doses of adrenaline to be used for different

Good

Are services safe?

ages to treat anaphylaxis was displayed. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of water supply, loss of the computer system and access to the building. There was provision to relocate the service to nearby premises if necessary. The document also contained relevant contact details for staff to refer to.

The practice had carried out annual fire risk assessments, which included actions required to maintain fire safety. Records showed that staff, including identified fire marshals, were up to date with fire safety training. Fire extinguishers had been tested in May 2014 and records showed that the fire alarm and security system was tested every three months and regular fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible on computers in all the clinical and consulting rooms. Staff told us that NICE guidance was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings, for example in July 2014, which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed.

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

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

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

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

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. The practice showed us 15 clinical audits that had been undertaken in the last 12 months. Three of these were completed audit cycles where the practice was able to demonstrate the changes resulting since the initial audit. We saw the results of an audit regarding continuity of care for patients conducted annually over the last three years, which involved a review of the patients' notes. These showed an increase in patients seeing their usual doctors, from 48% in 2012, 70% in 2013 to 77% in 2014. The practice was working towards a target of 90%. Other audits included one to check the post-operative infection rates following surgical procedures performed at the practice, which confirmed no infection had occurred. Another audit was a review of effectiveness of duty doctor triaging, which resulted in a number of learning points.

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

Good

Are services effective?

(for example, treatment is effective)

of High Dose Inhaled Corticosteroids in Asthma and Chronic Obstructive Pulmonary Disease (COPD). Learning points, shared with staff, included the need to consider reducing the medication if a patients is stable, testing the patients' inhaler technique and documenting whether a patient has given up smoking as a result of advice given by the practice, for example by attending the smoking cessation clinic.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.2% of the total QOF target in 2014, which was 5.7% above the national average and 4.9% above the CCG average. Specific examples of the practice results being above the national average included:

- Performance for diabetes related indicators.
- The percentage of patients with hypertension having regular blood pressure tests.
- Performance relating to mental health-related and hypertension QOF indicators.
- The dementia diagnosis rate.

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.

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

The practice had a palliative care register and we saw records of regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, for example, homeless patients, travellers and patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions, such as diabetes, COPD, heart failure. We were shown data that showed that structured annual reviews so far had been carried for 92% of patients on the diabetes register, 91% of patients on the COPD register and 96% of patients on the heart failure register.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date in receiving mandatory courses such as annual basic life support. We noted a good skill mix among the GPs, all of whom were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example one of the GPs had received additional training in bipolar affective disorder. 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 we spoke with.

Good

Are services effective?

(for example, treatment is effective)

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of childhood immunisations, flu, yellow fever and pneumonia vaccinations. Those with extended roles, for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease, were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from local hospitals including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 10.9% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice recorded and monitored follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, patients from vulnerable groups and those with end of life care need. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. In addition, for example, there were informal discussions between GPs and midwives at the end of each antenatal clinic. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. During the inspection, we spoke with the community matron, who was positive about how the practice engaged and worked with other services.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record, which is planned to be fully operational by 2015. (Summary Care Records (SCR) provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was information regarding the SCR available in the reception area was to be added to the website. The practice had a record of those patients who had dissented from having a summary care record created.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

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

Good

Are services effective?

(for example, treatment is effective)

how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also 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 had a section stating the patient's preferences for treatment and decisions. We saw that all patients on the practice's learning disabilities register had their care plans had been reviewed in last year. Staff showed us examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (This is used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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

Staff told us that there had never been an incident where the use of restraint had been necessary, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

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

It was practice policy to offer a health check 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 smoking cessation advice to smokers, running dedicated clinics for women, for patients aged over 75, and providing sexual health self-testing for all 16-24 year olds.

The practice also offered NHS Health Checks to all its patients. Practice data showed the uptake for the checks was 47%. Data showed that 93% of patients aged 45 and over had had blood pressure checks. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice maintained a register of patients with learning disabilities. We saw data that showed 18 of the 29 patients eligible for annual heath checks having been seen. The practice had plans in place for the remainder to be seen before April 2015. The practice also carried out annual physical health checks of people experiencing poor mental health. Data showed health checks had been carried out for 59% of the eligible 170 patients. The practice was looking at ways of improving the uptake of health checks in this patient group, as they often did not respond to standard recall letters. These included offering checks opportunistically, for example when patients attended the practice for repeat prescriptions, and contacting patients by phone to offer the checks.

The practice's performance for the cervical screening programme was 91.88%, which was above the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurses had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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

- Flu vaccination rates for the over 65s were 74.14%, and at risk groups 62.56%. These were above national averages.

Good

Are services effective?

(for example, treatment is effective)

- Childhood immunisation rates for the vaccinations given to under twos ranged from 92.8% to 98.2% and five year olds from 83.1% to 98%. These were above national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015, and three annual surveys conducted for the practice between 2012 and 2014.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 88% of patients who responded to the survey rated their overall experience of the practice as good. The practice was also scored above average for its satisfaction scores on consultations with clinical staff. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%

We also saw from the practice's annual survey results that patients were positive about the service. In 2012, 335 patients had responded, with 86% rating the service as good, very good or excellent. In 2013, 312 patients had responded, with 80% rating the practice as good, very good or excellent. In 2014, 295 patients had responded with 84% rating the practice as good, very good or excellent.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and all were positive 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. Two patients mentioned occasional delays in obtaining appointments and one patient said that waiting times at the surgery were sometimes long. We also spoke with eight patients attending appointments and three members of the Patient Participation Group. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). All told us they were satisfied with the care provided by the practice and said their dignity and privacy were respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A separate room was available should patients wish to discuss matters privately. No patients reported any concerns regarding privacy. Additionally, we saw that 91% of patients responding to the national patient survey said they found the receptionists at the practice helpful compared to the CCG and national averages of 87%.

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 investigate these and any learning identified would be shared with staff. We observed how receptionists dealt with patients from various patient groups attending for appointments. We saw that receptionists were friendly, sensitive and sympathetic. Children and young were people treated in an age-appropriate way.

Care planning and involvement in decisions about care and treatment

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

- 87% said the GP was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81%.

Good

Are services caring?

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The practice maintained records of the languages spoken by patients. After English, Turkish was the largest patient group and the practice arranged for a Turkish-speaking advocate to attend three times a week. In addition, two of the receptionists spoke Bengali.

We saw evidence on patients' records of their involvement in agreeing care plans, including end of life planning, if appropriate. The practice uses the 'You're Welcome' quality criteria for young people-friendly health services, produced by the Department of Health.

Patient/carer support to cope emotionally with care and treatment

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

- 86% said the GP was good at treating them with care and concern compared with the CCG average of 83% and national average of 85%.
- 83% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 90%.

We asked the practice manager about this last issue regarding nurses. They said that it had been noted and that suitable training had been arranged for the nursing staff in March 2015.

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

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. None of the patients we spoke with on the day had been bereaved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, GPs pro-actively visited housebound patients four times a year and had recently introduced an evening sexual health clinic to cater for working age patients.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications 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 population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, arranging for staff to receive customer service training and to set up electronic prescribing for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. In addition, the practice registered homeless patients and worked actively with the local drugs and alcohol teams and Family Action. There was a system for flagging vulnerability in individual patient records. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. A Turkish-speaking advocate attended three times a week.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. The first floor could be accessed by lift and there were evacuation chairs in place in the event of a fire. The consulting rooms were also accessible for patients with mobility difficulties and there were access-enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams and an area for children's play. This made movement around the practice easier and helped to maintain patients' independence.

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

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training as part of their annual mandatory refresher training and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice opening hours were 8.00am to 8.00pm on Monday and Wednesday; 8.00am to 7.00pm on Thursday and 8.00am to 6.30pm on Tuesday and Friday. It was closed for lunch between 1.00pm and 2.00pm and was closed at weekends. The practice had opted out of providing out-of-hours (OOH) services to patients and referred callers to the local OOH provider when the practice was closed. GPs made home visits to patients who could not attend the practice and a telephone consultation service was available, with either the duty doctor or the patient's named GP. The extended hours were convenient for families with children and working age patients. Appointments could be booked online. Patients told us they found the system easy to use. Text message reminders were sent confirming appointments.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term

Good

Are services responsive to people's needs?

(for example, to feedback?)

conditions. These included appointments with a named GP or nurse. Home visits were made to a local care home twice a week, with GPs conducting joint rounds with secondary care specialists.

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

- 88% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 73% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%.
- 71% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.
- 80% said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%.

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

Listening and learning from concerns and complaints

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

We saw that information leaflets were available at the practice and on the website to help patients understand the complaints system. Contact details were provided for the Health Service Ombudsman and independent advice and advocacy. Patients we spoke with were aware of the process to follow if they wished to make a complaint, but none had had cause to use the system.

We looked at a summary record of 51 complaints received in the last 12 months and several in detail. We found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the compliant. None had been referred to the Ombudsman and there were no identifiable trends.

The practice reviewed complaints to detect themes and identify learning issues. We saw that lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, targets had been introduced for answering the phone. These were monitored and the matter was added to the agenda of the reception team meeting for on-going review. In two cases, when patients had been unhappy with the outcome of appointments, their named GPs had been changed. We saw that complaints were discussed at practice meetings, with the minutes being available for all staff to share any learning.

We saw that the practice monitored and responded to comments patients had posted on the NHS Choices website.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's detailed statement of purpose. The practice vision and values included to "Treat patients with dignity and respect; understand the whole patient, their lives and background as well as their immediate medical needs; work with patients as equal partners to help them with their health needs; go the extra mile for patients especially when they are vulnerable and may need our support to help them access the services we think they need; and to treat the patient and their family as we would wish our families and ourselves to be treated."

Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We saw from minutes of practice meetings that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had numerous of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. These were produced by a GP practice management resource provider, which offers a comprehensive support service to subscribing practices. The policies and procedures had a note of their version number and review dates and we saw that all were up to date. Minutes of meetings confirmed that when policies and procedures had been updated staff were informed and the practice maintained a record to show when staff had read the policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and the two of the GP partners were leads for safeguarding children and vulnerable adults. All the staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework (QOF) to measure its performance. (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing better than the national average. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had carried out an audit of care plans and had identified certain learning points which it had asked the CCG to consider the next time the plan's design was reviewed. Evidence from other data sources, including incidents and complaints, was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, all consultation rooms had fitted with emergency alarms. Staff told us this was not just for when staff felt threatened, but was for use if a patient was in distress and needed urgent medical assistance. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy, probationary process, management of sickness and disciplinary procedure, which were in place to support staff. We saw that the probationary process was put to effective use. There were specific induction programmes for the various clinical and non-clinical roles. We were shown the electronic staff

Are services well-led?

Good

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

handbook that was available to all staff, which included sections on equality, harassment and bullying at work and whistleblowing Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

The partners were visible in the practice. Members of staff told us the partners were friendly, approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop it. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported by the practice management.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback through the patient participation group (PPG), surveys and complaints received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had an active, if small, PPG which included representatives from various population groups, met every three months. The PPG had 12 members, 6 female and 6 male, aged 32 to 71 and included patients who described themselves as White British, Black British, Turkish and Mixed Afro-Caribbean / White British. We spoke with several members of the PPG during the inspection and they were very positive about the role they played and told us they felt engaged with the practice. They told us the meetings took place at 5.00pm, which had led to a limited attendance, often fewer than ten. They told us that a "virtual PPG" was to be set up shortly, to increase patient involvement. The virtual PPG would make use of emails and online facilities, to allow more patients to comment on the service. The annual PPG reports, which included agreed actions, were available on the practice website. The website also provided information about the PPG and invited patients to join it. However, none of the patients we spoke with knew of the PPG or its function, suggesting there may be a need for the PPG to be better advertised and promoted to patients who might be not have internet access.

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

The practice had also gathered feedback from staff through an annual staff survey, and generally 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. Two members of staff told us that they had asked for specific computer training and this had been arranged. 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. We looked at seven staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice and had three registrars (trainee doctors) assigned. However, two were on maternity leave at the time of the inspection. Each registrar was mentored by one of the partners.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw that significant events were investigated and the outcomes were discussed at clinical meetings with appropriate learning points identified.