The Stroudley Walk Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 at Stroudley Walk Health Centre on 18 November 2013. 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 older people, people with long term-conditions, families, children and young people, the working age (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

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- We saw that older patients identified as at risk of isolation were discussed at monthly clinical meetings as well as multi-disciplinary meetings to address the support they required. Patients over 75 years old who were on the avoidable admissions register were given a separate number to call the practice to enable them to get through to the practice faster.

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

Action the provider SHOULD take to improve:

- Ensure a legionella risk assessment is completed to reduce the risk of infection to staff and patients and ensure records are in place to demonstrate the effective implementation of a cleaning schedule for the building.
- Ensure portable electrical equipment is routinely tested.
- To ensure all staff confirm they have read and understood governance policies.
- Define a unified vision for the practice to follow.

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. For example we saw a recent discussion of a significant event at a routine clinical meeting. It was recorded that a patient when attending the practice had become aggressive and displayed threatening behaviour, placing staff and patients at risk. An action plan was put in place including the strategies to manage the patient's behaviour if they visited the practice again. The event was discussed with all staff at a routine staff meeting. There was enough staff to keep patients safe. Staff received regular training and updates to equip them with the skills and knowledge to fulfil their job role. A legionella risk assessment had not been completed to reduce the risk of infection to staff and patients. Records also did not demonstrate the effective implementation of a cleaning schedule for the building.

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. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at monthly practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Patient's 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 planned. Staff appraisals and personal development plans were in place for all staff.

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 they were involved in decisions about their care and treatment. The data from the GP patient survey told us patients had confidence in the clinical staff they saw. For example, out of 63 patients who

Summary of findings

completed the survey, 85% said they had confidence and trust in the last GP they saw or spoke to and 91% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with 61% practice respondents saying the GP was good at listening to them and 23% saying it was neither good nor poor. 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.

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice responded quickly to issues raised and learned from complaints.

Are services well-led?

Good 

The practice is rated as good for being well-led.Although staff told us their own individual visions which centred around providing a person centred and caring service, the practice had not set out a clear vision in its strategy or business plan. There was a statement of purpose in place, but this was brief and did not define a unified vision for the practice to follow. However, we found the practice offered a friendly, caring, good quality service that was accessible to all patients. 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 (PPG) was in the process of being re- established. 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 as 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. Patients over 75 years old who were on the avoidable hospital admissions register were given a separate number to call the practice to enable them to get through to the practice faster. 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). Patients with long term conditions requiring repeat prescriptions were being seen, and reviews of their medications they were undertaken regularly.

There was a palliative care (end of life) register and patients on the register were discussed at the monthly palliative care meetings. The GP partner we spoke with used national standards for the referral of patients with chronic obstructive pulmonary disease and patients were referred within three weeks to pulmonary rehabilitation. 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 were seen for up to 45 minutes by the practice nurse.

Families, children and young people

Good

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

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The practice was responsive to the needs of the group, and staff said calls involving young patients were given urgent priority. There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. 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. Records demonstrated good liaison with partner agencies such as the police and social services. Clinical staff attended children protection case conferences and reviews where appropriate. 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 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 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. To assist working age patients in accessing the service there was also a text message reminder for appointments and test results. The practice was performing well in undertaking cervical smear examinations, and providing advice on smoking cessation advice. The practice's performance for cervical smear uptake was 76%, which was better than others in the CCG area. Seventy six percent of targeted patients had undergone cytology screening and there was a policy to offer telephone reminders for patients who did not attend for cervical smears. The practice also audited patients who did not attend annually.

The uptake for health checks with a blood pressure check for working age patients was at 90% with a patient count of 752 patients. The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 6.16% of patients in this age group took up the offer of the health check.

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People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group 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 and staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

Patients with a learning disability 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. 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. The practice referred all patients who were homeless to a local practice who registered these patients as part of a joint working initiative. 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 website offered patients information as to what to do in time of bereavement and referral arrangements were in place with a local counselling service.

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 the advocacy service available at the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group 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. Patients diagnosed with severe mental health and were discussed at the monthly clinical meetings which were held with the psychiatrist. The practice worked closely with the local community mental health team. An advocacy service was provided, which was advertised in the reception area to support

Summary of findings

patients in vulnerable circumstance and those suffering with 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 NHS England GP patient survey 2014 and a survey of 45 patients undertaken by the practice in 2012. The evidence from both of 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 NHS England GP patient survey showed patients had confidence in the clinical staff they saw. Out of 63 patients who completed the survey, 85% said they had confidence and trust in the last GP they saw or spoke to and 91% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the doctors with 61% of respondents saying the GP was good at listening to them and 23% saying it was neither good nor poor. The majority of patients at 63 % said the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. These had been completed by patients in the two week period before our inspection and enabled patients to record their views about the practice. We received 31 completed cards and the majority 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. One comment was less positive about available appointments and we noted there were no common themes. We also spoke with three patients on the day of our inspection. They told us they were

Areas for improvement

Action the service MUST take to improve

Action the provider MUST take to improve:

- Ensure a legionella risk assessment is completed to reduce the risk of infection to staff and patients. Records to demonstrate the effective implementation of a cleaning schedule for the building.
- Ensure portable electrical equipment is routinely tested.

Action the service SHOULD take to improve

- To ensure all staff confirm they have read and understood governance policies.
- Define a unified vision for the practice to follow.

Outstanding practice

- We saw that older patients identified as at risk of isolation were discussed at monthly clinical meetings as well as multi-disciplinary meetings to address the support they required. Patients over 75 years old who were on the avoidable admissions register were given a separate number to call the practice to enable them to get through to the practice faster.

The Stroudley Walk Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP.

Background to The Stroudley Walk Health Centre

Stroudley Walk Health Centre operates from 38 Stroudley Walk, London, E3 3EW. The practice provides NHS primary medical services through a Primary Medical Services contract to just over 4,000 patients in the Tower Hamlets Area. The practice is part of the Tower Hamlets Clinical Commissioning Group (CCG). It comprises of two full time male GPs, a locum female GP, three practice nurses, two healthcare assistants, a practice manager and a small team of administrative staff. The practice is a training practice and was providing placements to two year two foundation programme students.

Appointments were available from 8.00 am to 20.00 pm on weekdays from Monday to Friday. GP consultation times were from 9.00 am to 12.30 pm and then 16.00 pm to 18.00 pm on Monday, Tuesday, Wednesday and Friday. On Thursday and Saturdays GP's saw patients during the morning from 9.00 am to 12.30 pm. Up to 15 urgent appointments were made available each day and GPs also completed telephone consultations for patients in need of urgent advice.

The practice has a PMS contract (Personal Medical Services agreements are locally agreed contracts between NHS England and a GP practice) and provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, and contraception services.

The practice had a higher than average percentage of patients between the 20-34 year age group.

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.

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 and asked other organisations to share what they knew. We carried out an announced visit on 18 November 2014. During our visit we spoke with a range of staff such as one of the GP partners, practice nurses, practice manager, administrative staff. We spoke with three

Detailed findings

patients. We reviewed personal care or treatment records of patients. 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)

Good

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 and 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.

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.

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

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 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 and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system she used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, we saw a patient had been diagnosed with throat cancer which had spread to their lung. The urgent referral had been delayed, as the patient was inappropriately referred to the Ear, Nose and Throat (ENT) department. It was a month later when a two week referral was completed by the practice. Learning was discussed at a routine clinical meeting. All staff were made aware of new guidelines that were due to be introduced for the two week wait referrals. The patient had been given an apology and informed of the actions taken. Significant events were routinely discussed at staff meetings. For example we looked at a recent discussion of a significant event at a routine clinical meeting. It was recorded that a patient when attending the practice had become aggressive and displayed threatening behaviour, placing staff and patients at risk. An action plan was put in place including the strategies to manage the patient's behaviour if they visited the practice again. The event was discussed with all staff at a routine staff meeting.

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. 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 which were on the shared computer system and displayed in staff offices.

The practice had appointed one of the GP partners as the dedicated GP lead in safeguarding vulnerable adults and children. All three GPs had been trained to level three in child protection, the practice nurses to level two and all other non-clinical staff to level one. They demonstrated they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

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. The practice used a computer programme which alerted clinical staff when seeing patients if they were identified as 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 records demonstrated good liaison with partner agencies such as the police and social services.

We saw the medical notes of a child who was on the child protection register. An alert was in place and safeguarding notes had been completed by clinical staff. We also saw the vulnerable adults register which included 69 patients. Clinical staff attended children protection case conferences and reviews where appropriate. Reports were sent if they were unable to attend and scanned into the system and into the patient's medical records.

Although the computer system for identifying children and young people with a high number of A&E attendances could be used, there was no regular auditing or monitoring of the system by the practice.

There was a system for reviewing repeat medications for patients with co-morbidities/multiple medications, which was also monitored by the quality outcomes framework (QOF), a system the practice completes to monitor their performance and in return for good practice received payment. There were 493 patients with more than four repeat prescriptions which were monitored and reviewed through QOF.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a 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. Fridge temperatures were taken each day and an audit trail was kept.

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

We saw records about actions taken to monitor prescribed medications. Practice meetings noted the actions taken in response to a review of prescribing data, including prescribing patterns of methotrexate used to treat auto immune conditions, nitrofurantoin anti-biotic, analog insulin to control diabetes and statins used to lower cholesterol levels.

The 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 nurses and the health care assistant had received appropriate training to administer vaccines. All three practice nurses and both of the healthcare assistants had recently received clinical immunisations and vaccines updates. A member of the nursing staff was qualified as an independent prescriber which meant she could prescribe any licensed medicine for any medical condition within their competence including some controlled drugs. We were told by the practice manager she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The GP advisor supporting us on the inspection checked five anonymised patient records which confirmed that the procedure was being followed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and 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 which were replaced every six months.

The practice had a lead for infection control which was one of the practice nurses who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The training was completed in 2013 and the practice manager was in the process of booking a refresher course. 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. We saw evidence that the practice had carried out audits for the last three years and that any improvements identified for action were completed on time.

Good

Are services safe?

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. We spoke to one of the practice nurses, who gave us examples of when she would use personal protective clothing. There was also a policy for needle stick injury,

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 a policy for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). However, a legionella risk assessment had not been completed to reduce the risk of infection to staff and patients.

Cleaning schedules were in place for toys at the practice, which were cleaned weekly and written records were kept of this. However, records for cleaning of practice which was completed everyday by an external cleaning contractor were not kept.

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. However portable electrical equipment was not routinely tested and displayed stickers indicated the last testing date was in 2007. We saw evidence of calibration of relevant equipment completed on an annual basis such as the vaccine fridge, ultra sound, spirometer, weighing scales, defibrillator and nebuliser.

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, the three files for newly recruited reception staff we looked at had proof of identification, references, 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. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The practice was in the process of recruiting a salaried female GP, to ensure female patients could see a female GP and allow patients to access a GP of their preferred gender.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Annual audits were also completed for new medicines, controlled drugs, waste management. The practice 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 who was the practice manager.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, we saw the medical notes for one patient who was diabetic and had a heart attack at the practice. The appropriate medical treatment was given and the patient was taken to the local accident and emergency department. The incident was recorded as a significant event and discussed at the practice meeting.

Good

Are services safe?

There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. Four patients were on the palliative care register and were discussed at the monthly palliative care meetings and on checking their medical notes; we saw that they had their medications reviewed. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Forty patients were diagnosed with severe mental health and were discussed at the monthly clinical meetings which were held with the psychiatrist.

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. The notes of the practice's significant event meetings showed staff had discussed a recent medical emergency concerning a patient and had explored how improvements could have been made if any to the action that had been taken.

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. 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 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 contained relevant contact details for staff to refer to. For example, contact details of the landlord, key holders and gas provider to contact if the heating system failed. The contact details of all the local emergency services such as out of hours and the local accident and emergency department were also listed.

All fire equipment such as the fire alarm and extinguishers had been checked in October 2014 and were in good working order. The practice had not carried out a fire risk assessment to maintain fire safety. Records showed that staff were not up to date with fire training and did not practise regular 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 for the practice's performance, the patients discussed and the required actions agreed. We saw the meeting minutes where a patient's complex care plan was discussed with other clinical staff such as the district nurse and the local out of hour's service, to ensure their care was planned and coordinated. The staff we spoke with and the evidence we reviewed confirmed that assessments were designed to ensure that each patient received support to achieve the best health outcomes for them.

The GPs told us they lead in specialist clinical areas such as diabetes, safeguarding, medication management and maternity and the practice nurses supported this work, which allowed the practice to focus on specific conditions. 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 for the management of sexual health, respiratory disorders and vaccines. Our review of the clinical meeting minutes confirmed this happened.

The Stroudley Walk Health Centre is a training practice and provided medical student and GP trainee placements. 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 shared with us two completed audit cycles undertaken by medical students currently placed at the practice. These included audits which looked at the management of nitrofurantoin anti-biotic and analog insulin to control diabetes. Following the audit, the GPs carried out medication reviews for patients who were diagnosed with diabetes and also discussed a new drug to treat diabetes at a clinical meeting. GPs maintained records showing how they had evaluated the service and documented the success of any changes. The practice showed us five other clinical audits that had been undertaken in the last two years. Audits were in safeguarding children, to ensure correct safeguarding procedures were followed in line with practice policies and procedures and in vitamin D, improvement of care, cancer and MRI's for knees and shoulders, to confirm that the GPs were working in line with their registration and NICE guidance.

The team was making use of their 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.

We were shown data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and a regular review. 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. The GP partner we spoke with used national standards for the referral of patients with chronic obstructive pulmonary disease and patients were referred within three weeks to pulmonary rehabilitation. 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.

Good

Are services effective?

(for example, treatment is effective)

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, managing child protection alerts and medicines management.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Out of 752 patients who required a blood pressure checks, 90% had been seen and out of 816 patients who required a smear test, 76% had been seen. The practice was on target for annual medication reviews for patients with diabetes and had seen 96.28% of patients. The practice met all the minimum standards for QOF in diabetes/asthma/ Chronic Obstructive Pulmonary disease. For example in June 2014 they had completed an annual review for 100% of their patients diagnosed with severe COPD.

There was a protocol for repeat prescribing 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 of 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 had reviewed the use of the medicine in question and, where they continued to prescribe it. 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 had achieved and implemented the gold standards framework for end of life care. It had a palliative care register of 13 patients and had monthly internal as well as external multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included two full time partner GPs, a full time locum GP, three practice nurses, two healthcare assistants, 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 and practice nurses with two practice nurses having additional diplomas in diabetes care. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example such as performing spirometry, coronary heart disease, chronic disease management, family planning which the practice nurses had attended. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback from the two trainees we spoke with regarding the support they received.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, for the administration of vaccines and cervical cytology they had received cytology updates and vaccines updates during clinical meetings. Those with extended roles seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease and sexual health were also able to demonstrate that they had appropriate training to fulfil these roles.

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 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 within the last year of any results or discharge summaries that were not followed up appropriately.

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet patient's needs and manage complex cases. It held monthly multidisciplinary team meetings 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, social workers, 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 A&E. 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. However, audits had not been completed on this system to assess the completeness of patient medical records to address any shortcomings identified.

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. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. 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. This policy 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. 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 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 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. Patients were offered opportunistic chlamydia screening aged 18-25 and smokers were offered smoking cessation advice. QOF data showed us that out of 719 patients identified as smokers, 79% were given smoking advice and 91% of patients diagnosed with a chronic disease were given advice and support.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

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 of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 76%, which was better than others in the CCG area. Seventy six per cent of patients had undergone cytology screening and 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 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.

The practice offered sexual health advice to patients at sexual health clinics which included advice on contraception.

The uptake for health checks with a blood pressure check for working age patients was at 90% with a patient count of 752 patients.

The practice referred all patients who were homeless to a local practice who registered these patients as part of a joint working initiative. The practice held monthly meetings with a psychiatrist to discuss all patients on their register experiencing poor mental health. There were 14 patients on the register and we saw meeting minutes discussing patients' care plans and treatment options. The practice also worked closely with the local community mental health team. An advocacy service was provided, which was advertised in the reception area to support patients in vulnerable circumstance and those suffering with poor mental health.

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 NHS England national patient survey 2014 and a survey of 45 patients undertaken by the practice in 2012. 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 63 patients who completed the survey, 85% said they had confidence and trust in the last GP they saw or spoke to and 91% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with 61% practice respondents saying the GP was good at listening to them and 23% saying it was neither good nor poor.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the majority 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. One comment was less positive about available appointments but there were no common themes to these. We also spoke with three patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, all receptionists had also undertaken training and stepped in. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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 and was shielded by glass partitions which helped patient information to be kept private. In response to patient confidentiality, 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. Two panic alarms were also situated behind the reception desk for staff to use in the event of an emergency.

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.

Two practice nurses had received training in equality and diversity and consideration was at being given providing this to the remaining staff team.

The practice manager told us they had a high number of patients experiencing depression and poor mental health. The practice had an advocacy service which was advertised in the reception area and patients were told about the service during consultations to support them through treatment programmes and daily living tasks.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed 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 national patient survey showed 51% of respondents said the GP involved them in care decisions. Fifty nine per cent of patients felt the GP was good at explaining treatments and results. The results from the practice's own satisfaction survey showed that 90% of patients rated their satisfaction with the practice as very good and above.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt

Good

Are services caring?

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 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.

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. The patient also told us their GP called them at home following a bereavement to offer support and they could not fault the practice and the services it offered.

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 the advocacy service.

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 people'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 found the practice to be involved in actively re-organising a Patient Participation Group (PPG) which had stopped meeting due to non-attendance of members. The practice website and posters in the reception area was advertising for patients to join and gave them information on what was involved. A virtual PPG group was also being set up, where patients were involved with the PPG through email, phone, text, letters and social media websites. We spoke with a previous member of the PPG who said they were very happy with the efforts the practice had taken to involve patients in their care and the action that was being taken to re-establish the group after it had ceased due to low attendance. They felt that their concerns were listened to and suggestions were always implemented.

The needs of the practice population were understood and systems were in place to address identified needs. The practice used a health informatics system which helped clinical staff to detect and prevent unwanted outcomes for patients and a scorecard system, to compare performance with other practices. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

We saw that older patients identified as at risk of isolation were discussed at monthly clinical meetings as well as multi-disciplinary meetings to address the support they required. Patients over 75 years old who were on the avoidable admissions register were given a separate number to call the practice to enable them to get through to the practice faster.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We saw the numbers of patients on the learning disability register, those experiencing poor mental health, patients identified as 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, which we saw minutes of, 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 access to interpreter services, which they booked in advance. Members of the reception staff, one of the GPs and nurses spoke a range of languages including Bengali, which was the most spoken language in the area.

The practice provided equality and diversity training two practice nurses completed in the last 12 months, which were confirmed by certificates. Although, this training had not been provided to the remaining staff team, equality and diversity was regularly discussed at staff appraisals and 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 a disabled toilet there were also baby changing facilities. The practice was situated on the ground floor with all services for patients operating from this floor.

Access to the service

Appointments were available from 8.00 am to 8.00 pm on weekdays from Monday to Friday and from 9.00 am to 12.00 pm on Saturdays. GP consultation times were from 9.00 am to 12.30 pm and then 4.00 pm to 6.00 pm on Monday, Tuesday, Wednesday and Friday. On Thursday and Saturdays GP's saw patients during the morning. Up to 15 urgent appointments were made available each day and GPs also completed telephone consultations for patients.

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 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 also available for people who needed them and those with long-term conditions and

Good

Are services responsive to people's needs?

(for example, to feedback?)

were seen for up to 45 minutes with the nurse. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one, such as older patients and those with long term conditions.

Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment and were seen by their GP the same day. They told us they were very pleased with the appointment system.

The practice's extended opening hours during the weekday evenings and Saturday morning were particularly useful to patients with work commitments.

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. Young people could speak to staff in private and a sexual health clinic was available.

To assist working age patients in accessing the service there were extended opening hours in place, an easy to use online booking system, text message reminders for appointments and test results.

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.

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

We looked at four complaints received in the last 12 months and found all 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 to detect themes and trends. 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

We saw a statement of purpose but this was brief and did not define a clear vision for the practice. There was also no evidence of strategy or business planning documents. However, staff outlined a vision for the practice which was to offer a friendly, caring and good quality service that was accessible to all patients.

We spoke with six 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. We looked at 12 of these policies and procedures but staff had not completed a cover sheet to confirm that they had read and understood the policy. All 12 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 nurse for infection control and one of the GP partner was the lead for safeguarding, medication management audits and the care of patients with diabetes. We spoke with six members of staff who told us they felt valued, well supported and knew who to go to in the practice with any concerns. Members of the reception team told us they felt supported and were encouraged to learn and develop their career.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. For example, we saw minutes for a staff meeting where QOF data had been monitored and was on track for meeting targets.

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 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 shared with us two completed audit cycles undertaken by medical students currently placed at the practice. These included audits which looked at the management of nitrofurantoin anti-biotic and analog insulin to control diabetes. Following the audit, the GPs carried out medication reviews for patients who were diagnosed with diabetes and also discussed a new drug to treat diabetes at a clinical meeting. GPs maintained records showing how they had evaluated the service and documented the success of any changes. The practice showed us five other clinical audits that had been undertaken in the last two years. Audits were in safeguarding children, to ensure correct safeguarding procedures were followed in line with practice policies and procedures and in vitamin D, improvement of care, cancer and MRI's for knees and shoulders, to confirm that the GPs were working in line with their registration and NICE guidance.

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

Identified risks were included on a risk log. 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. For example, the practice manager had shared the recent findings of an infection control audit with the team and the risks posed to staff and patients of not following infection control protocols. However, the information did not include a legionella risk assessment to reduce the risk of infection to staff and patients

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

Are services well-led?

Good

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

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly and always took place. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. 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 electronic staff handbook that was available to all staff, which included sections on equality, harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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 looked at the results of their practice survey which was to examine the level of services offered to patients. The practice patient survey 2012 highlighted that patients were unable to book appointments two weeks in advance. As a result systems were put in place so patients could book appointments online. The GP patient survey told us patients had confidence in the clinical staff they saw. For example, out of 63 patients who completed the survey, 85% said they had confidence and trust in the last GP they saw or spoke to and 91% of patients said the same about the last nurse they saw.

We found the practice to be involved in actively organising a Patient Participation Group (PPG) which had stopped meeting due to non-attendance of members. The practice website and posters in the reception area was advertising for patients to join and gave them information on what was involved. A virtual PPG group was also being set up, where patients were involved with the PPG through email, phone, text, letters and social media websites.

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.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

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 nine staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Stroudley Walk Health Centre was a training practice and provided medical students and GP trainee placements. We spoke to two Year two foundation programme students who spoke positively about the practice and the support they had received. The informed us they had regular supervision and received regular tutorials.

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 and a dedicated meeting was held monthly 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.