

# Stovell House Surgery

## Quality Report

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

## Ratings

### Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Stovell House Surgery on 15 October 2014.

We rated Stovell House Surgery overall as good. We rated it as good for four of the five questions we ask at inspection. We rated it as requires improvement for providing safe services. We rated it as good at providing services to the six population groups we report on at inspection.

Our key findings were as follows:

- The practice clinical team referenced published evidence based guidance and their local clinical commissioning group care pathways in the delivery of care and treatment, and in ensuring positive health outcomes for its patients

- The practice used the Quality and Outcomes framework to measure, monitor and improve performance; and was performing better when compared to other practices in the area and against national averages.
- The practice was responsive to people's needs, including those of various groups of people in vulnerable circumstances
- The practice was well led, and had been a teaching practice for many years

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

Importantly, the provider must:

- ensure a programme of audit of infection control arrangements is in place to ensure that key policies and practices are being implemented appropriately

In addition, the provider should:

- ensure the practice manager receives annual appraisal in line with the practice policy.

# Summary of findings

- ensure the infection control lead has up to date training to support them to carry out all aspects this role effectively
- ensure chaperone training is provided to staff who carry out these duties to reinforce their understanding and support their performance of these roles.
- ensure medicines are appropriately stored in fridges with allowances made for particularly busy periods such as during seasonal flu vaccination.
- ensure that their recruitment policy is followed in the recruitment of new staff

**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?

The practice is rated as requires improvement for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons learnt were communicated widely to support improvement in the practice. Information about safety was recorded, monitored and reviewed appropriately. There were enough staff to keep people safe.

Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe, particularly in relation to infection control. In addition, information to help patients understand the complaints system was not made readily available.

Requires improvement



### Are services effective?

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. There were regular multidisciplinary meetings and working arrangements in place to ensure patients received care to meet all aspects of their healthcare needs.

Staff had received training appropriate for their roles and further training needs were identified with plans for training to be updated.

Most staff had received appraisals and personal development plans were in place for all staff. However the practice manager had not received an annual appraisal since 2010.

Good



### Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than other practices in the local area for several aspects of care. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. We also saw that staff ensured patient confidentiality was maintained. Patients we spoke with during 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.

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where they were identified.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from the Patient Participation Group (PPG).

Patients told us that access to the practice was good. They had a named GP and could choose to see a GP of their choice for continuity of care. Longer appointments were made for those who needed them and urgent appointments were available the same day. The practice management shared learning from complaints with the staff team.

Good



## Are services well-led?

The practice is rated as good for well-led. The practice carried out proactive succession planning. There was constructive staff engagement and staff were happy in their roles. The practice sought feedback from patients, and had a virtual patient participation group (PPG). The PPG had recently been remodelled and plans were in place for them to begin face to face meetings.

All staff had received inductions. The majority of staff received regular performance reviews. Team meetings were held and staff received development opportunities. The practice was a GP training practice.

The practice had a number of policies and procedures to govern the operation of the practice; however the revisions arrangements could be improved to reduce the risk of staff referring to out of date versions at later dates.

Good



# 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

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its patient population and had a range of enhanced services, including dementia care and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with complex needs. Flu vaccinations were offered to patients over the age of 65. The practice provided flu vaccinations to 64.4% of its patients who were over the age of 65 during the winter of 2013/14; the national average for the same period was 73.2%. This winter (2014/15), the practice introduced weekend vaccinations which took place over two Saturdays during September 2014 to ensure a higher uptake of vaccinations.

Good



### People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals were made for patients that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. The named GP worked with relevant health and care professionals for patients with complex care needs to ensure the delivery of a multi-disciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-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 and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours. Staff provided us with good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Good



# Summary of findings

## **Working age people (including those recently retired and students)**

Good



The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this population group.

## **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. The practice held a register of patients living in vulnerable circumstances including people of no fixed abode and those with learning disabilities. The practice had carried out annual health checks for patients with learning disabilities. The practice offered longer appointments for patients with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector 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 and out of hours.

## **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). Staff regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had advance care planning arrangements in place for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

We spoke with eight patients during our inspection. The practice had a patient participation group (PPG) and we spoke with one member of the group. We also received completed comment cards from 38 patients. The feedback we received was from a variety of patient groups including working patients, retired, patients with long term conditions and patients who did not speak English as a first language. The comments we received about the practice were positive and complimentary of the staff team. Patients gave us various examples of what the practice had done to meet their individual care needs.

33 of the comments cards we received were entirely positive with patients commenting that they received a

good standard of care. Patients often remarked on the friendly and helpful nature of the reception staff team, and also named specific members of the clinical team and other members of staff as having given them care and support that met their needs. The remaining five comments cards were partly positive and patients partly expressed some elements of dissatisfaction. Four comments where respondents expressed dissatisfaction related to issues in getting appointments and one was about physical access via wheelchair into the building.

The 2014 national GP patient survey results aligned with the views of patients we spoke with on the day, with 86% of respondents saying they would recommend the surgery (the CCG average was 75%).

## Areas for improvement

### Action the service **MUST** take to improve

The provider must operate a programme of audit of infection control arrangements is in place to ensure that key policies and practices are being implemented appropriately

### Action the service **SHOULD** take to improve

The practice should ensure the practice manager receives annual appraisal in line with the practice's human resources policies.

The practice should ensure the infection control lead has up to date training to support them to carry out all aspects this role effectively

The practice should ensure chaperone training is provided to staff who carry out these duties to reinforce their understanding and support their performance of these roles.

The practice should ensure medicines are appropriately stored in medicines fridges with allowances made for particularly busy periods such as during seasonal flu vaccination.

The practice should ensure that their recruitment policy is properly followed in the recruitment of new staff



# Stovell House Surgery

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. They were granted the same authority to enter the registered persons' premises as the CQC inspector.

The practice staff team comprised two GP partners (one male, one female), three salaried GPs, one GP registrar, two practice nurses, two healthcare assistants, a practice manager, and six administrative staff and eight receptionists.

Stovell House Surgery is a GP training practice.

As of July 2014, the practice had 7071 patients, made up of close to 70% 15 to 64 year olds, 15% over 65s, and the remaining 17% were 14 years and younger.

## Background to Stovell House Surgery

Stovell House Surgery is located in Addiscombe, within the London borough of Croydon. Its premises at 188 Lower Addiscombe Road comprise a two storey detached Victorian building.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, family planning services, maternity and midwifery services, surgical procedures, treatment of disease, disorder or injury. The practice is able to provide these services to all groups in the population.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

## Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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.

# Detailed findings

## How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

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 15 October 2014. During our visit we spoke with a range of staff (doctors, nurse, practice manager and reception staff) and spoke with patients who used the service.

We observed staff interactions with patients and talked with carers and/or family members.

We reviewed documentation and arrangements relating to the operation of the practice such as policies and procedures, their patient records system, staff records and certification to verify the health and safety of the premises. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

# Are services safe?

## Our findings

### Safe Track Record

The practice used a range of information sources to identify risks to patients and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a prescribing incident was recently reported which led to an update to the repeat prescribing procedures and training update to all staff involved in prescribing medicines.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. They showed the practice had managed incidents consistently over time and so could evidence a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of the seven significant events that had occurred during the last 12 months and these were made available to us. The discussion of significant events was a standing agenda item on the practice clinical meeting agenda. This included the review of actions from past significant events and complaints. We saw evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

We saw incident forms were available in the practice, and completed forms were reviewed by the practice manager.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in patients. They were also aware of their responsibilities regarding

information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details for sharing safeguarding concerns were easily accessible.

There was a GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary competence to enable them to fulfil this role. All staff we spoke to were aware who the lead GP was for safeguarding 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 so staff were aware of any relevant issues when patients attended appointments.

A chaperone policy was in place and displayed on the waiting room noticeboard and in consulting rooms. The nursing staff and health care assistants were the only staff who acted as a chaperone. They demonstrated through our interviews with them that they understood their responsibilities in relation to providing this support to patients, however they had not had chaperoning training. Staff who carried out chaperone duties had received Disclosure and Barring service (DBS) checks. Patients we spoke with understood that the chaperone service was available and how to access it.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers) were identified and followed up by the clinical team. There was support, advice and signposting offered to carers by the GPs. The practice signposted people who were carers to drop in café sessions offered in Croydon.

There was a system in place in the practice for identifying children and young people with a high number of emergency services attendances, and children who persistently fail to attend appointments such as for their childhood immunisations.

# Are services safe?

There was a system to highlight vulnerable patients, and for reviewing repeat medications for patients with co-morbidities and /or patients taking multiple medicines.

## Medicines Management

We checked medicines stored in the treatment rooms and medicines refrigerators and found they were stored securely and were only accessible to authorised staff.

We examined the contents of two medicines fridges in the practice and found they were both overstocked, with items touching the sides. The practice staff explained to us that this overstock was temporary due to the current seasonal flu campaign under way in the practice. As a result they had received a recent delivery of 1100 doses of the vaccine, which were due to be administered during the week of our inspection.

Public Health England Protocol for ordering, storing and handling vaccines (published March 2014) states that all fridges should ideally have two thermometers, one of which is a maximum / minimum thermometer independent of mains power. One of the practice's medicines fridges did not have maximum / minimum thermometers, and only recorded static temperatures. However the practice medicines fridges also had alarms on them which were programmed to activate should they go out of temperature range.

The nursing staff told us there had been an incident earlier in the year when the fridge had been accidentally disconnected from its power supply and the contents had had to be destroyed. Following this incident there was now a clear label displayed next to the fridge power supply indicating it must not be switched off.

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.

Vaccines were administered by nurses and the healthcare assistant using directions that had been produced in line with legal requirements and national guidance. All staff who administered vaccines had up to date training to support them to perform immunisations competently.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that

generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us that all prescriptions were reviewed and signed by a GP before they were given to a patient.

## Cleanliness & Infection Control

We observed the premises to be clean and tidy on the day of our inspection. Cleaning schedules were in place and records of all cleaning carried out were maintained. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

All staff received induction training about infection control specific to their role. The senior practice nurse was the lead for infection control, and was able to describe to us the processes they followed to ensure equipment and patient areas remained clean. We saw that all equipment used was single use. However we found that the infection control lead had not undertaken further training to support them to carry out the role effectively. We saw no evidence that the infection control lead had carried out infection control audits for each of the last three years to monitor the practice's infection control arrangements and check that they were operating satisfactorily.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. There were policies for needle stick injury, spills and sharps storage.

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

Hand sanitiser was available in the reception area, and positioned in a clearly visible location.

The practice had arrangements in place for an external company to complete a risk assessment for legionella (a germ found in the environment which can contaminate water systems in buildings). The assessment had been completed in April 2013 and highlighted actions that the practice needed to take to minimise risks. The practice had taken the recommended actions.

# Are services safe?

## Equipment

Staff we spoke with told us they had sufficient 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 stickers were displayed indicating the last testing date.

## Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment of most staff. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found for the latest staff member, recruited within the last few months, the recruitment policy had been not been completely followed. References had not been obtained prior to the commencement of their employment. We discussed with the practice manager, who told us they were in the process of obtaining the relevant references.

There were two partner GPs in the practice, who both worked eight sessions a week. There were also three salaried GPs and one GP registrar. The practice rarely used locum GPs, as the GPs covered each other's absences, such as annual leave. There were also two practice nurses, two healthcare assistants, eight reception staff members and six administrative staff members.

Rotas were in place for the administrative and reception staff to ensure sufficient staff cover.

## Monitoring Safety & 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. The practice also had a health and safety policy. However we found that infection control audits were not being carried out at regular intervals to monitor the practice's infection control arrangements and check that they were operating satisfactorily.

A quarterly health and safety audit was carried out in the practice. This included checks of the electrical appliances, emergency lighting, exterior of the premises, fire procedures, and hazardous substances. Any identified required actions following the audit were documented and responded to. For example, in January 2014 the audit highlighted that fire extinguishers in the premises had become due for service. The necessary service was carried out following the audit.

Equipment in the practice was subject to annual calibration (a procedure for checking the equipment was functioning as designed, and that it was taking accurate measurements). Records showed that all the equipment was in date for calibration checks.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For patients with long term conditions there were emergency processes in place. The GPs gave us examples of referrals made for patients that had a sudden deterioration in health. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and in the use of the automated external defibrillator (AED). Emergency medicines and an AED (used to attempt to restart a person's heart in an emergency) were available in the practice. All staff we asked knew the location of this equipment and records we saw confirmed the equipment was checked regularly.

Emergency medicines were available and kept in a secure area of the practice and all staff knew how to locate them. This included medicines for the treatment of cardiac arrest, anaphylactic reactions and hypoglycaemia (low blood sugar). All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned

## Are services safe?

sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with clearly outlined the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. Our discussions with the GPs and nurses confirmed that they completed thorough assessments of patients' needs, in line with NICE guidelines.

The GPs told us they had lead responsibility in specialist clinical areas such as diabetes, heart disease, women's health and asthma and the practice nurses supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. At the time of our inspection, the practice had a GP registrar in training with the practice, who received regular and on-going supervision and mentorship from the senior GPs.

The practice offers cryotherapy in-house, and minor surgeries were performed by a visiting GP. One of the GPs in the practice fitted long acting reversible contraception. The practice was accredited to provide minor surgery procedures under the Directed Enhanced Service (DES) from 1st April 2014 at the levels for which your participating GPs are accredited.

The GPs we spoke with used a number of evidence based resources including pathways for specific conditions. They used online resources such as patient.co.uk and published guidance such as those issued by National Institute for Health and Care Excellence (NICE). The practice GPs also followed the referral pathways set by their clinical commissioning group, Croydon Referral Support Service (CRESS). One of the GPs gave us an example of how through using the CRESS, a referral for a routine gastroenterology appointment had been diverted to a more urgent two week referral.

All referrals in the practice were peer reviewed by the GPs in their daily morning meetings.

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

### Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

Staff showed us two of the clinical audits that had been undertaken in the past year. The first audit was of 999 calls and people accessing emergency department services. This audit aimed to gain an understanding of the reasons patients were making 999 calls, and if that was the most appropriate form of care for them when they did. The first cycle was undertaken in May 2012 and found in a number of cases, the 999 service was not being used appropriately. The practice implemented changes following the first cycle which included educating patients about appropriate use of emergency services, using posters, their website, face to face consultations and letters. The practice had also introduced a case management system for patients who inappropriately used emergency services or who were frequent attendees. Following these changes, a second cycle was undertaken in May 2013. In the second cycle of audit, the practice found there had been no significant changes in the numbers of patient using 999 calls to access emergency services; however, the use seemed to be more appropriate in the second cycle.

The second audit being conducted by the practice that we reviewed was of the uptake of preschool immunisations booster for D/TaP immunisation. D/TaP is diphtheria (D), tetanus (T) and acellular pertussis (aP) (whooping cough). The first cycle of this audit found that the practice uptake was 93%, above the Department of Health recommendation of 90%. Recognising that the higher the number of vaccinated patients, the healthier the total population would be as a whole, the practice implemented a number of actions to increase uptake. They aimed to obtain a copy of the red book (personal child health record) for any patient falling in the relevant age category to ensure

# Are services effective?

## (for example, treatment is effective)

they have up to date information about their immunisation history and address any gaps. An information pack was prepared with the recent evidence showing the risks of immunisation versus the risk of non-immunisation and given to patients as required, alerts to be set up on the patient records system, EMIS, reminding staff when immunisations were due, and the electronic screens in the waiting room will be used to highlight the importance of immunisation and reminding parents of the immunisation schedule. A second cycle of this audit was scheduled for September 2015.

The practice was a high achiever in Quality and Outcomes Framework (QOF) performance. ) QOF is a national performance measurement tool. In the 2013/ 14 year, the practice achieved 97.9% in its QOF performance, 5.1 percentage points above CCG average, and 4.4 percentage points above England average.

However the practice identified areas where their QOF performance could be improved, for example, in diabetes care and management. The practice partners and practice nurse had attended a training programme in diabetes management to help improve in this aspect.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the practice used their QOF performance to drive improvement in their immunisations. This practice was not an outlier for any QOF (or other national) clinical targets.

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 the latest prescribing guidance was being used. The practice GPs also met daily to discuss referrals and sign prescriptions. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

Practice nurses also maintained their professional registrations. The nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, the senior practice nurse had undertaken training in the management of certain long term conditions, Asthma and Diabetes.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses. For example a practice nurse that had just joined the practice was sent on a travel vaccination course. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support.

### Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and taking action on any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. The GPs discussed all incoming correspondence as part of their daily meetings.

The practice held monthly multidisciplinary team meetings and palliative care meetings to discuss the needs of complex patients and those with end of life care needs respectively. These meetings were attended by district nurses, social workers, community matrons, community pharmacists and palliative care nurses. Decisions about care planning were documented in a shared care record.



# Are services effective?

## (for example, treatment is effective)

The practice also held Monday morning meetings that were attended by external colleagues to discuss particular cases and plans of care for particular individuals.

### Information Sharing

The practice used several electronic systems to communicate with other providers. For example, they used the Croydon Referral Support service (CRESS) for making referrals to secondary and allied services.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff 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.

Information governance and Confidentiality training was mandatory for all staff in the practice, and we saw evidence that they had all attended these training sessions within the last twelve months.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children's and Families Act 2014 and their duties in fulfilling the Acts. 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.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and we saw that there was a template form for this.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

### Health Promotion and Prevention of Ill Health

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The health check documented, among other information, their height, weight, smoking status, alcohol consumption, and family health history. The GP was informed of all health concerns detected and these were followed-up in a timely manner. New patients who were unable to attend the practice for this appointment could request a home visit.

The practice offered NHS Health Checks to all its patients aged 40-75, and a healthcare assistant ran clinics twice a week for patients who wanted to access this service.

There was a broad range of information leaflets and posters in the practice waiting area. These covered information about specific conditions, such as stroke, cancer and asthma; health support information, such as smoking cessation programmes and weight loss programmes; and leaflets with information about accessing external support agencies such as Macmillan cancer support.

The practice identified the smoking status of patients over the age of 16 and offered in-house smoking cessation clinics to these patients. 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 offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for seasonal flu vaccinations was below the national average. This year the practice held two Saturday morning clinics specifically for flu vaccinations, which saw up to 500 patients receiving vaccines at each of the clinics.

The practice staff maintained a register of patients who are identified as being at high risk of admission, patients requiring palliative care, and had up to date care plans in place for them. The practice held multidisciplinary meetings to discuss the care needs of older patients at high risk of admission and patients requiring palliative care. There was provision of a named GP for patients over the age of 75

# Are services effective?

(for example, treatment is effective)

For patients with long term conditions (LTCs) including diabetes, chronic obstructive pulmonary disease (COPD), heart failure, there were structured annual reviews. Data on the practice performance supported that they provided the group of people with regular checks, including checks for signs of other illnesses. For example, 64% of patients on the diabetes register had had a blood pressure reading of 140/80 or less in the preceding 15 months, the national average was 72.9%. 69.3% of patients on the diabetes register in whom the last IFCC HbA1c is 64 mmol/mol or less in the preceding 15 months, the national average was 75.5%. IFCC HbA1c is a measure of how much haemoglobin in the blood has become glycated.

Health promotion and healthy lifestyle advice was documented in patients' notes. There was a system for risk stratifying patients and identifying those at high risk of developing LTCs (using the electronic patient record). Patients with LTCs also had a named GP and multidisciplinary case management meetings were held to discuss their care.

For families, children and young people, the practice's immunisation rates for all standard child immunisations was similar to CCG average for children at 12 and 24 months old. Standard immunisations rates for children at five years old was below the CCG average. The practice had audited their performance in this area and had made arrangements to help increase uptake.

Chlamydia was the biggest health concern among the young people in the area. The practice staff signposted young people at risk to sexual health clinics and offered them advice.

The practice staff worked with local midwives and health visitors in providing care to mothers and their children.

The practice offered Health Checks to patients of working age. Cervical screening checks are provided to women according to national guidelines.

The practice held a register of patients in various vulnerable groups, including people with learning disabilities and those needing palliative care. There was multidisciplinary working in the case management of vulnerable groups, and patients were signposted to various support groups and third sector organisations.

For people experiencing poor mental health, additional checks and assessments were made of them. The patient notes of 93.3% patients with physical and / or mental health conditions contained an offer of support and treatment within the preceding 15 months. A high percentage of patients (97.3%) with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption in the preceding 15 months recorded. Alcohol consumption is adversely linked to mental illness, and records of alcohol consumption among patients with mental illness is an indicator that the matter is being discussed with patients, along with health promotion and lifestyle advice. As with other vulnerable groups, there was multidisciplinary working and case management of the care of this group of people, as well as referrals to other organisations.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey, a practice conducted survey reviewing access and waiting times, and feedback from the practice's Patient Participation Group. The evidence from all these sources showed patients were satisfied with the care and treatment they received, and that it was with compassion, dignity and respect. Patients felt listened to and involved in decisions about their care. For example, data from the 2014 national patient survey showed the practice was rated above average for the CCG area for its satisfaction scores on consultations with doctors and nurses with 87% of practice respondents saying the GP was good at listening to them and 88% saying the GP gave them enough time. 81% of practice respondents said that the nurse was good at giving them enough time and 78% said that the nurse was good at explaining tests and treatments. 86% of respondents said they would recommend this surgery to someone new to the area.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 38 completed cards and the majority were positive about the service experienced. The comments we received about the practice were consistently positive about the practice and its staff team. Patients gave us various examples of what the practice had done to meet their individual care needs. Patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. Five comments were less positive, mostly related to issues in getting appointments and one was about physical access via wheelchair into the building. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

The notice in the patient reception area stating the practice's zero tolerance for abusive behaviour was clearly visible.

People whose circumstances may make them vulnerable were able to access the practice without fear of stigma or prejudice. We saw examples during our inspection where the staff treated people from this group in a sensitive manner.

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

The patient survey information we reviewed showed patients gave mixed responses to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed only 64% of practice respondents said the GP involved them in care decisions (below the local average), although 84% felt the GP was good at explaining treatment and results (above the local average).

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 patients this service was available.

Staff spoke other languages including French and Greek.

## Are services caring?

For older people and people with long term conditions, care plans were developed with them or people close to them. Where appropriate this included noted discussions about end of life care planning.

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

Patients we spoke with were positive about the emotional support provided by the practice. They told us that help to access support services to help them manage their treatment and care was available when required. The comment cards we received were also consistent with this feedback.

Leaflets in the patient waiting room directed people to 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, some of which was on the practice website, to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement received a telephone call from their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. The practice manager also told us that news of a death of a patient was posted on the staff noticeboard in the kitchen and sympathy cards were sent to the family of the patient. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

# 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. The practice used a risk stratification tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice used their local CCG referral system, Croydon Referral Support Service (CRESS), to electronically refer patients for care in alternative settings and to ensure they received the care that was right for them.

The practice implemented an annual seasonal flu vaccination campaign. This year they had opened on two consecutive Saturdays specifically to allow patients to attend for a flu vaccine. Staff told us that the campaign had been well publicised in the practice and they had been able to complete more than a thousand vaccines over the two Saturdays and were close to achieving their annual target at the weekend campaign. They had also communicated with patients that were in at-risk groups but had not received a vaccine yet, to encourage them to attend at later dates. There was a plan in place to invite people that were recommended to have flu vaccination to have it.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

There had been the recent retirement of one the partner GPs in the practice, and a nurse had left for a more senior post that could not be offered at the practice. Prior to that, there had been very little turnover of staff during recent years which enabled good continuity of care and accessibility to appointments with a GP of choice.

Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to patients who were unable to attend the surgery.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, improvements have been made to the online appointments system making them more user friendly for patients.

The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment.

For older people and people with long term conditions, home visits, same day appointments and longer appointments were available where needed. A named GP was provided for people over the age of 75 for continuity of care.

Appointments were available outside of school hours and there were extended opening hours for children and young people, and patients whose work made accessing the service at routine opening times difficult.

There was partnership working to understand the needs of the most vulnerable in the practice population. The practice accepted patients registering on a temporary basis, or those who needed to be seen as 'immediate necessary'. The practice arranged to obtain relevant information from the patient's usual practice if they had one.

Mental health needs of the practice population was monitored and informed service provision. Longer appointments were provided for those who needed them. Flexible services and appointments were also provided including for example, avoiding booking appointments at busy times for people who may find this stressful.

### Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services.

# Are services responsive to people's needs?

(for example, to feedback?)

The practice treated patients who were temporary residents in the area and contacted their permanent practice, if they had one, for any additional information that would support them to receive continuity in their care.

The practice had access to telephone translation services.

The practice provided equality and diversity training as part of the mandatory training for its staff team. Staff records showed that all staff had completed the equality and diversity training in the last two years, and new staff members had completed the training since joining the practice.

The premises and services had been adapted to meet the needs of people with disabilities. Patients who were unable to use the stairs were provided with appointments in consultation rooms on the ground floor. Their needs were indicated in their notes so that when appointments were made for them they were done appropriately. There was a ramp at the entrance of the premises to provide wheelchair users access to the building.

A hearing loop system was in operation in the practice to support people with hearing difficulties. Guide dogs for people with sight and hearing difficulties were allowed in the practice. Blue badge car park spaces were available outside the practice.

A register of people who may be living in vulnerable circumstances was maintained in the practice, and a system was in use for flagging vulnerability in individual records. People were able to register with the practice, including those with "no fixed abode".

## Access to the service

The practice was open from 8.30am to 6.30pm, Monday to Friday in line with their contract. Appointments were available from 08:30am to 11:15am then 4:30pm to 6.30pm on weekdays. Extended hours were provided from 6.30pm to 8pm on Mondays, and also on the last Saturday of each month. Appointments were available with the GPs, nurses and healthcare assistants in the practice for any registered patient. Routine appointments were available up to 6 months in advance and could be made by telephone or in person in the practice. Single appointments were ten minutes long, but patients were able to book double appointments if they had several issues to discuss.

Urgent appointment slots were made available each day. The practice also offered alternate means of accessing

care. Treatment and support including home visits, telephone consultations, emails (for non-medical issues) and a text messaging service for people who were hard of hearing. Patients were also able to ring to speak with a doctor between 11.45am and 12.45pm or nurse between 12.30pm – 1pm.

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

An electronic check-in terminal was available in the practice waiting area. The terminal was well positioned, and offered a selection of community languages.

Patients were generally 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.

The results of the 2014 national GP patient survey found that 86% of patients found it easy to get through to this surgery by phone, and were able to get an appointment to see or speak to someone the last time they tried. In addition, 96% said the last appointment they got was convenient.

The practice staff told us their extended opening hours on Mondays was particularly intended for patients with work commitments.

The practice was situated in a Victorian building, with consultation rooms on the ground and first floors. There was no lift access between floors but patients who were not able to use the stairs had their appointments made for consultation rooms on the ground floor. The practice manager told us that notes were attached their patient



# Are services responsive to people's needs?

(for example, to feedback?)

record so that when they rang to make an appointment the system immediately flagged their mobility needs. There was a ramp leading to the practice entrance, to assist wheelchair users in accessing the premises.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

An online repeat prescription service was available in the practice. Telephone consultations were available and GPs are available to speak with patients on the telephone at the end of their morning appointments. These services may be of particular benefit to working patients who were not able to easily access the practice in their routine opening times.

## **Listening and learning from concerns and complaints**

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

A complaints leaflets and form was available in the practice from the reception team, but complaints information was not displayed in the waiting area. Information about complaints was available on the practice website.

We looked at nine complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way. Complaints were discussed with staff and at staff meetings. For example following a customer complaint, customer care and how to speak with patients was made an agenda item at a staff meeting.

# 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 statement of purpose document in place. This set out the aims and objectives of the practice which encompassed the provision of high standards of clinical care, collaborative working with their primary care team, and maintaining high standards of educational support for doctors, student and staff. Our interviews with staff and patients and the governance arrangements in the practice aligned with these objectives. This showed that the objectives were reflected in the arrangements and culture in the practice.

The practice partners articulated their vision as being ensuring 'patients come first'. They told us they felt able to stay focused on this, as they gave their practice manager lead of the business side of operating the practice. This allowed them to focus on the patients care.

The partner GPs in the practice had attended training for leadership. The practice was an empowering practice, and we saw that non-clinical duties were delegated to other staff.

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice intranet. We found that the printed policies and procedures were not the latest revisions. The practice manager told us they maintained a revisions folder, which they ensured all staff signed that they had read and understood the revisions updates to policies and procedures. The records confirmed this, but we found that the system was not joined up and there was a risk of practice staff referring to out of date policies and procedures at later dates.

The practice held Monday morning clinical meetings where they discussed core aspects of their practice, such as ongoing multidisciplinary work, palliative care and their performance against the Quality and Outcomes Framework (QOF). The QOF data for this practice showed it was a high performer, achieving 97.9% in the 2013 / 14 year, a score which was 5.1 percentage points above the CCG (local) average, and 4.4 percentage points above the England average. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We found there were clear lines of reporting and responsibilities within the practice. The GPs and nurses were able to focus on clinical side of the practice, and the practice manager led on the business side. Lead roles were assigned for particular aspects of the practice operations, such as Quality and Outcomes framework (QOF) monitoring, governance, infection control and safeguarding. Practice staff were clear about who had the lead roles in different aspects of the service.

The practice had conducted a number of clinical audits to improve practice standards. A recent audit completed was of 999 calls and an audit that was being undertaken was of the uptake of school age childhood immunisations boosters.

The practice met monthly with other local practices in their CCG network. The practice manager shared with us a recent agenda for the meeting, which showed matters discussed included how practices intended to deliver their plans care. Each practice's plans were reviewed by their colleagues and they discussed how they would work together to make sure each practice was able to deliver their plans. The practice manager stated that all the practices shared constructive feedback provided a knowledge resource bank for one another.

The practice management team also attended open CCG meetings which anyone in the Borough was able to attend.

The practice manager told us the practice management team was engaged with their local CCG, and regularly received communications about new care pathways they needed to follow, and enhanced services to be delivered. They also met with the CCG prescribing lead to discuss prescribing plans and best practice.

### Leadership, openness and transparency

We were shown a clear leadership structure chart which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an



# Are services well-led?

Good 

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

open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every 6 months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including the recruitment policy and induction policy, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff. The handbook included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

## **Practice seeks and acts on feedback from users, public and staff**

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of their most recent annual patient survey, which focussed on checking that they had sought improvements to their waiting time and access from the previous year.

The results of the latest survey were reviewed with the PPG in January 2014. The aim of the latest survey was to see if the practice had improved from the previous year in terms of access and waiting times for appointments. The survey found that fewer respondents now reported waiting 20 minutes or longer for their appointments than in the previous year. The practice had taken action to address longer waiting times by changes they had implemented in their appointments system.

The practice had also introduced a hearing loop and a mobile telephone text message service for deaf patients. An online appointments booking system was also now in operation, and the practice was offering more telephone consultations to provide patients greater flexibility in accessing services and in improving availability of face to face consultations.

The practice had a virtual patient participation group (PPG), made up of 60 members. They communicated by email, provided feedback to the practice, and conducted and reviewed the results of practice surveys with the practice management team. The PPG had recently become reconstituted as a face to face group. The first in person meeting of the PPG was held on 16 October 2014. The PPG meeting was attended by four PPG members, the practice manager and practice administrator. Matters discussed at

the meeting included the appointment of an acting chair, the draft constitution of the PPG, ground rules and what the group hoped to get out of the PPG. The PPG member we spoke with told us they felt there was a genuine commitment and support from the practice to the development of the PPG.

The practice GPs held daily meetings, where they met to review correspondence that had been received that day and to sign prescriptions.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Regular meetings held in the practice included weekly Monday morning clinical meetings, nurses' meeting and all staff meetings.

There was a staff appraisal system in place, which supported staff to receive annual appraisals. We looked at a recent appraisal that had been completed and found that there was a self-assessment section as well as evaluation sections. However we found that the practice manager had not received an annual appraisal since 2010. The practice partners recognised this was the case and understood the need to prioritise this support for the manager.

The practice had a whistle blowing policy which was available to all staff electronically.

The practice prepared a quarterly newsletter for its patients, which was available in the practice waiting area and on their website. We looked at the most recent newsletter, and found it had relevant and useful information for patients. The newsletter had up to date news, such as staff joining and leaving, as well as helpful reminders about patient responsibilities and seasonal requirements, such as making travel vaccinations appointments well ahead of travel dates, seasonal flu vaccinations and reminders about the processes for repeat prescriptions, referral letters and results.

## **Management lead through learning & improvement**

Stovell House surgery had a long and established history of education. The practice was a GP training practice, able to accommodate a maximum of three registrars in training for placements of between four and 12 months. The practice also provided training for FY2 doctors and final year students. The senior partner in the practice was the trainer, local appraiser of GP, and examiner for the Royal College of

# Are services well-led?

Good 

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

GPs (MRCGP). As a GP training practice, Stovell House surgery had been formally approved and was regularly re-approved to provide training to training, new and specialising doctors.

The second partner in the practice was in training to become a GP trainer.

The practice now has two partners. Since the recent retirement of the third partner another GP had been appointed, salaried for 18 months in a probationary capacity and if satisfactory would be invited to become a partner. This new GP had previously been the training registrar within the practice, demonstrating that the practice showed commitment to developing and promoting its members of staff.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The GPs attended study days and remained up to date with their awareness of available services in the community for different groups of people. On the day of our inspection, a new practice nurse was on a

two day course in travel vaccinations. The practice manager gave us an example of how they had encouraged and supported a previous practice nurse to become a nurse practitioner even though they did not have a vacancy for the more senior post once they had completed their training. This led the nurse practitioner finding a more senior post in another organisation.

We looked at one staff file 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 had attended relevant training for their roles.

The practice had completed reviews of significant events and other incidents and shared the information with staff via meetings to ensure the practice improved outcomes for patients. For example, following a prescription error, changes had been made to the repeat prescription protocols to ensure certain medicines could not be issued as a repeat prescription.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p><b>How the regulation was not being met:</b></p> <p>The registered person did not ensure that are service users, persons employed and others who may be at risk of exposure were protected against identifiable risks of acquiring such an infection. Regulation 12 (1)</p> <p>This was because a programme of audit of infection control arrangements was not in place to ensure that key policies and practices are being implemented appropriately.</p>