Dr Geraldine Golden & Dr Michael Abu

Quality Report

Dr G Golden and Dr M Abu Surgery
Kenton Bridge Medical Centre
155-175 Kenton Road
Kenton
Harrow
Middlesex
HA3 0YX
Tel: 02089076013
Website: www.kentonbridgemedicalcentre.org.uk

Date of inspection visit: 4 February 2015
Date of publication: 23/07/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 8

Areas for improvement 8

Detailed findings from this inspection

Our inspection team 9

Background to Dr Geraldine Golden & Dr Michael Abu 9

Why we carried out this inspection 9

How we carried out this inspection 9

Detailed findings 11

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 04 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement for providing safe services. The practice was also good for providing services for older people, people with long term conditions, families children and young people, working age people including those recently retired, people whose circumstances make them vulnerable, and people experiencing poor mental health (including those with dementia).

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

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

We saw one area of outstanding practice:

Summary of findings

- The practice offered special clinics for patients with addictions and worked closely with a local susbstance misuse service. Patients were able to attend weekly pre-arranged sessions with a psychologist.

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

Importantly the provider should

- Ensure a record is made of learning from incidents and significant events.
- Ensure recruitment arrangements include all of the necessary employment checks for staff.
- Ensure the role of non-clinical staff is risk assessed and Disclosure and Barring Checks are carried are carried out as required. The practice should undertake a risk assessment to determine which non clinical members of staff are eligible for a Disclosure and Barring Check as determined by their role in patient care.
- Ensure training is provided on the role of chaperone.
- Ensure that the management of vaccines is consistent with the cold chain 'policy'.
- Ensure there is a system to call for assistance in an emergency.
- Ensure audit cycles are completed to drive continual improvement.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, improvements to processes were required. There were inconsistencies between staff action and the guidance in the chaperone policy and the policy of the safe storage of vaccines.

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 National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The patient survey carried out by the practice had identified a dissatisfaction regarding the availability of appointments. The practice had responded to this by employing an additional GP.

Summary of findings

Patients said there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people. Ninety six per cent of older patients had been informed in writing of their named GP. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice nurse had undertaken specialist training to support patients with long term conditions. Patients with asthma were monitored and support and advice was given on the use of inhalers. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were relatively high for all standard childhood immunisations with 90% of eligible children receiving their booster immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). 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 worked with local substance misuse services and offered clinics twice a week for people with addictions.

Appointments were available outside of working hours for people who could not attend the practice during the day.

Summary of findings

People whose circumstances may make them vulnerable

Good

he practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability and all of these patients had received an annual review.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Seventy per cent of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Seventy three per cent of people with dementia had their care reviewed in the last year.

Summary of findings

What people who use the service say

We spoke with three patients on the day of the inspection and received 39 comments cards completed by patients prior to our inspection visit. We also looked at the results of the national patient survey.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of 245 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for nurses giving patients enough time during their consultation.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered good service and staff were efficient, helpful and caring.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations. Patients we spoke with gave us examples of how GPs had involved them in their care and explained the treatment process to them. The GP of one patient had explained that treating a medical condition was a three step process of assessment, diagnosis and then a discussion on the relevant medical treatment. Patients were satisfied with their medical assessment and were referred to secondary health care services where necessary.

Comments from patients we spoke with and who completed comments cards informed us that staff were supportive and helped then to cope emotionally. Patients gave examples of being supported throughout personally difficult circumstances.

Areas for improvement

Action the service SHOULD take to improve

- Ensure a record is made of learning from incidents and significant events.
- Ensure recruitment arrangements include all of the necessary employment checks for staff.
- Ensure the role of non-clinical staff is risk assessed and Disclosure and Barring Checks are carried are carried out as required. The practice should undertake a risk assessment to determine which non clinical members of staff are eligible for a Disclosure and Barring Check as determined by their role in patient care.
- Ensure training is provided on the role of chaperone.
- Ensure that the management of vaccines is consistent with the cold chain 'policy'.
- Ensure there is a system to call for assistance in an emergency.
- Ensure audit cycles are completed to drive continual improvement.

Dr Geraldine Golden & Dr Michael Abu

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 and a CQC inspection manager. The GP specialist advisor was granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Geraldine Golden & Dr Michael Abu

The practice is located in Harrow and provides a general practice service to around 6,505 patients. Dr G Golden and Dr M Abu provide primary medical services through a General Medical Services contract which is in place with NHS England. The surgery premises at Kenton Bridge are shared with another registered GP practice. The practice was due to move to a larger premises and a site for this had been located close to the existing practice. A new building was going to be constructed and this was in the early stages of the planning process.

The practice is open from Monday to Thursday 08:00 to 19:00. Appointments with GPs are available between 08:00 and 19:00 Monday to Thursday. On Friday the practice is open and offers appointments from 08:00 until 18:30. Extended appointments are available with the practice nurse between 18:30 and 19:00 Monday to Thursday. The practice has opted out of providing out-of-hours service to patients, and patients were advised to ring the local out-of-hours provider. The telephone number for the provider was on the practice website.

The practice offers a range of services including clinics for patients that included childhood immunisations, the management of diabetes and long term conditions. An ear, nose and throat clinic was held at the practice once a week.

The practice has a higher than average number of patients aged between 20 and 34 and a higher number of female patients who are over the age of 85. The practice has a large diverse ethnic mix of Black African, Black Caribbean, Eastern European, British White, Other White and Asian population.

The practice team is made up of four GPs, two male and two female and one practice nurses. Three receptionists were employed at the practice to cover the reception area on a rota basis during opening times. A General Medical Services contract is in place with NHS England.

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.

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 04 February 2015. During our visit we spoke with a range of staff including the practice manager, two GPs, two practice nurses, and reception staff.

We spoke with three patients who used the service and looked at the minutes of Patient Participation Group (PPG) meetings. A PPG is a group of volunteer patients who meet with practice staff to discuss the services provided at the practice. We received 39 comment cards completed by patients in the two weeks prior to our inspection.

We observed how patients were being spoken with and spoke with three patients. We reviewed CQC patient comments cards where patients had shared their views and experiences of the service with us.

Requires improvement

Are services safe?

Our findings

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses and made changes to improve practice. For example, improving administration and storage to ensure that relevant paperwork can be easily accessed. We reviewed safety records, incident reports and minutes of meetings. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice had recorded five significant events during 2014. Learning from significant events and complaints was not routinely recorded. For example the practice had responded to a medical emergency which had taken place outside of the practice. Practice staff responded appropriately and the outcome was good. Practice staff informed us this had been discussed at a staff meeting; however a recording of learning had not been made.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner.

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 the majority of staff had received relevant role specific training on safeguarding. Clinical staff had received training in child protection to Level 3 apart from the nursing assistant who was trained to Level 1. All staff at the practice had received safeguarding training which was provided by the local CCG in 2014.

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 safeguarding concerns and knew how to contact the relevant agencies in working hours and out of normal hours. Staff we spoke with were able to demonstrate their knowledge of the safeguarding protocol and how they would take the appropriate action regarding concerns, for example, reporting their concern to the safeguarding team/lead. Staff discussed patients who were at risk in clinical meetings and there was evidence of this in the clinical meeting minutes we viewed.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. 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. Staff could access safeguarding policies and procedures on all desk top computers at the practice.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The policy contained guidelines on the role of the chaperone during an intimate medical examination. The policy indicated that clinical staff would act as a chaperone. Some staff were not clear on the policy and who could act as a chaperone; we were told that non clinical staff could act as a chaperone. Risk assessments on the need for a DBS check had not been completed for non-clinical staff.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The safe storage of vaccines had been reviewed in the infection control audit which took place in 2014. The policy The policy set out procedures to maintain the 'cold chain' However, the policy was not clear on the use of vaccines which had been temporarily removed from the fridge and then returned to the fridge, which meant that the cold chain had been broken.

Requires improvement

Are services safe?

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 in line with waste regulations.

The nurse 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. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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. Staff we spoke with were aware of the process for issuing paper prescriptions. These were kept securely and the serial number of issued prescriptions was recorded. This process included prescriptions kept in the emergency medical kit.

We spoke with staff who demonstrated that there were adequate safeguards in place for repeat prescribing. Repeats were authorised by the GPs and re – authorisation was formalised beyond the prescribing period if this was required. A GP was designated each day as the 'duty' GP; it was their task to attend to repeat prescription requests. The majority of prescriptions were being issued electronically

and these could be issued to a pharmacy of the patients choice for collection.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. We saw that controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. A register was in place for the issue of controlled drugs which required the signature of two clinical staff.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

An infection control policy and procedure was in place which set out how staff were to manage all aspects of cleanliness and infection control at the practice. The practice nurse was the infection control lead. The practice was observed to be clean and tidy on the day of the inspection. There was a decontamination protocol and a cleaning schedule which set out the tasks to be completed at the end of each day in the clinical and non-clinical areas. Infection control policies were available and displayed in clinical areas.

An infection control audit had been carried out by NHS England in March 2014 and the practice had achieved the score of 100%. This meant there were no follow up actions as a result of the audit. The infection control lead had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. An infection control update had been delivered to the staff team on the 6 January 2015.

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. The infection control policy was displayed in clinical areas.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The practice had commissioned a legionella test which was conducted in February 2015.

Equipment

Routine maintenance of the fire system and equipment took place and records indicated that the last service had taken place in April 2014 with fire extinguishers being serviced in January 2015.

Safe track record

Requires improvement

Are services safe?

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses and made changes to improve practice. For example, improving administration and storage to ensure that relevant paperwork can be easily accessed. We reviewed safety records, incident reports and minutes of meetings. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice had recorded five significant events during 2014. Learning from significant events and complaints was not routinely recorded. For example the practice had responded to a medical emergency which had taken place outside of the practice. Practice staff responded appropriately and the outcome was good. Practice staff informed us this had been discussed at a staff meeting; however a recording of learning had not been made.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner.

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 the majority of staff had received relevant role specific training on safeguarding. Clinical staff had received training in child protection to Level 3 apart from the nursing assistant who was trained to Level 1. All staff at the practice had received safeguarding training which was provided by the local CCG in 2014.

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 safeguarding concerns and knew how to contact the relevant agencies in working hours and out of normal hours. Staff we spoke with were able to demonstrate their knowledge of the safeguarding protocol and how they would take the appropriate action regarding concerns, for example, reporting their concern to the safeguarding team/lead. Staff discussed patients who were at risk in clinical meetings and there was evidence of this in the clinical meeting minutes we viewed.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. 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. Staff could access safeguarding policies and procedures on all desk top computers at the practice.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The policy contained guidelines on the role of the chaperone during an intimate medical examination. The policy indicated that clinical staff would act as a chaperone. Some staff were not clear on the policy and who could act as a chaperone; we were told that non clinical staff could act as a chaperone. Risk assessments on the need for a DBS check had not been completed for non-clinical staff.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The safe storage of vaccines had been reviewed in the infection control audit which took place in 2014. The policy The policy set out procedures to maintain the 'cold chain' However, the policy was not clear on the use of vaccines which had been temporarily removed from the fridge and then returned to the fridge, which meant that the cold chain had been broken.

Requires improvement

Are services safe?

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 in line with waste regulations.

The nurse 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. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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. Staff we spoke with were aware of the process for issuing paper prescriptions. These were kept securely and the serial number of issued prescriptions was recorded. This process included prescriptions kept in the emergency medical kit.

We spoke with staff who demonstrated that there were adequate safeguards in place for repeat prescribing. Repeats were authorised by the GPs and re – authorisation was formalised beyond the prescribing period if this was required. A GP was designated each day as the 'duty' GP; it was their task to attend to repeat prescription requests. The majority of prescriptions were being issued electronically

and these could be issued to a pharmacy of the patients choice for collection.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. We saw that controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. A register was in place for the issue of controlled drugs which required the signature of two clinical staff.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

An infection control policy and procedure was in place which set out how staff were to manage all aspects of cleanliness and infection control at the practice. The practice nurse was the infection control lead. The practice was observed to be clean and tidy on the day of the inspection. There was a decontamination protocol and a cleaning schedule which set out the tasks to be completed at the end of each day in the clinical and non-clinical areas. Infection control policies were available and displayed in clinical areas.

An infection control audit had been carried out by NHS England in March 2014 and the practice had achieved the score of 100%. This meant there were no follow up actions as a result of the audit. The infection control lead had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. An infection control update had been delivered to the staff team on the 6 January 2015.

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. The infection control policy was displayed in clinical areas.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The practice had commissioned a legionella test which was conducted in February 2015.

Equipment

Routine maintenance of the fire system and equipment took place and records indicated that the last service had taken place in April 2014 with fire extinguishers being serviced in January 2015.

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. Medical equipment had been calibrated in November 2014.

Staffing and recruitment

Records we looked at contained evidence that overall the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We looked at the recruitment records of the most recent member of staff to join the practice who had been recruited to a non-clinical role. The required recruitment documentation was in place apart from proof of identity. A Disclosure and Barring Service (DBS) risk assessment had not been carried out.

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. We saw evidence of an emergency staff meeting which had been called in response to the sudden long term absence of a clinical member of staff. The meeting minutes demonstrated staff had responded to this and had discussed how the rota would arranged to meet the needs of patients.

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. The practice also had a health and safety policy.

There were water stains on the celling throughout parts of the practice. The practice manager had contacted the landlord on a number of occasions, however this maintenance issued had not been resolved. One consultation room did not have an emergency panic button. However, the GP we spoke with said the appropriate emergency procedures were in place and there was access to emergency equipment such as oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency drugs were kept in each consultation room.

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 in 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. We saw a record to evidence that emergency medicines were checked monthly. 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 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 if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that

they practised regular fire drills. Routine maintenance of the fire system and equipment took place and records indicated that the fire alarm system had been serviced in 2014 and fire extinguishers January 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. Staff informed us that NICE guidelines were also reviewed at external clinical meetings. Information from these meetings was then disseminated to colleagues at the practice during staff meetings.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, substance misuse, dermatology and gynaecology and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The two GP partners were equally responsible for leading in child protection and safeguarding adults. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Clinical staff were able to describe the appropriate mechanism for ensuring continuity of care and referrals.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. Clinical staff informed us that audits were carried out in accordance with QOF and CCG prescribing guidelines.

The practice showed us four clinical audits that had been undertaken in the last year. None of the four audits formed part of a completed clinical audit cycle. The practice had undertaken an audit on lancets (to enable diabetic patients to monitor their blood sugar; referrals; Non-Steroidal anti-inflammatory drugs (NSAIDS) and asthma inhalers. The practice was able to demonstrate the changes made as a result of the audit on asthma inhalers. The outcome showed that there was a more than expected use of 'reliever' inhalers and combination inhalers. This led to changes, with patients being recalled and reviewed. However there had not been any re-audit to measure the impact on patient care. Staff informed us that the outcome of audit information was discussed and reviewed at clinical meetings.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had achieved 100 QOF points out of a possible total of 100.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

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, fire safety and safeguarding. We noted that staff had received training relevant to their role. The practice nurse had a diploma in family planning and the principles of infection prevention. The practice nurse had also undertaken additional training

in managing long term conditions such as diabetes and asthma. Locum GPs who worked at the practice were invited to staff meetings and paid for their time when they attended.

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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in cervical screening, and monitoring patients with long term conditions such as cardiopulmonary disease and asthma. The practice nurse was the smoking cessation lead and offered spirometer testing (measurement of lung capacity) and had received training for this role.

A register was in place for patients who have an enduring mental health problems. Patients on this register were offered annual health checks including vitamin D testing which the practice introduced after attending a talk on this subject. We reviewed the care plans of 27 patients on the learning disability and mental health register. Seventy per cent of patients diagnosed with a mental health condition had attended the practice for their annual health check. The practice follows up patients who do not attend their annual review and liaises with other mental health services in the social and healthcare sector.

One of the GP partners had a special interest in treating patients with addictions and two clinics were held at the practice weekly. The practice manager had the additional role of supporting patients in this category and had obtained the RCGP (Royal College of General Practitioners) certificate in drug misuse Level 1

Working with colleagues and other services

Clinical meetings were scheduled once every two months. These were attended by the GPs, practice nurses, district nurses and the practice manager. The last clinical meeting took place in December 2014.

Meeting minutes we reviewed indicated that patient care, the palliative register, QOF statistics were discussed. Administrative staff met once every three months to discuss the management of patient information, health and safety at the practice, and contacting patients from different groups who were eligible for health checks and reviews.

The practice worked with the local short-term assessment, rehabilitation and reablement service (STARRS). The service offered rapid response with a multi-disciplinary assessment of patients needs. A review of patient records indicated that the practice was working closely with STARRS regarding the assessment and care of patients.

GPs at the practice attended a monthly peer group meeting with colleagues from the local CCG. This was a forum for GPs in the area to present patient case studies and look at different aspects of patient care. A midwife from a local hospital attended practice multidisciplinary team meetings once a week. GPs attended a local GP forum which met monthly. Consultants from local hospitals were invited to these meetings to talk about their area of medical specialism.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It 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. There were systems in place to manage patient care and the reception administrative staff we spoke with were aware of this. Test results were forwarded directly to the designated GP who would then task administrative/reception staff to make contact with the patient as necessary.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through

Good

Are services effective?

(for example, treatment is effective)

the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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. Reception and administrative staff we spoke with said there were systems in place to manage patient correspondence and records. There was a daily allocation of correspondence and faxes a designated GP. Test results were forwarded directly to the identified GP who initiated an electronic task on the system requesting administrative/reception staff make contact with patients as necessary for follow up appointments.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We discussed examples of consent and mental capacity with staff who gave clear examples of the practice having documented patient decisions. Where patients were unable to consent information was recorded on the designated 'power of attorney' and 'next of kin'.

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 are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff we spoke with were able to identify issues of consent. We saw that the consent had been sought and recorded in patient's electronic record.

We saw that the practice had sought written consent for minor surgery and verbal consent for the fitting of contraceptive devices. Verbal consent was recorded in patients records.

Health promotion and prevention

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We asked the practice for information on the number of patients who had attended their health check; the practice did not provide this information. The practice had placed a machine in the corridor close to the consultation rooms which patients could use for checking their own weight and blood pressure.

Patients over the age of 75 had a named GP. Ninety six percent of patients in this category had been informed of their named GP. Seventy three per cent of patients at the practice who were diagnosed with dementia had their care reviewed in the last twelve months, in comparison to 88% within the local CCG area. The care of all patients who were on the palliative care registered was reviewed with every three months. Older patients were offered the seasonal flu vaccination. Sixty seven per cent of patients in this category had received the vaccine.

A local nursing home was registered with the practice. The nursing home offered a service to 60 older people, some of whom have a diagnosis of dementia. A GP from the practice visited the home weekly and offered a consultation for between 15 and 20 patients. The practice offered a local enhanced service to a residential home for ten adults with a learning disability. All of the patients who are registered with the practice with a learning disability had an annual review of their care.

The management of patients with long term conditions was shared between the GPs and the practice nurse. Patients with long term condones such as asthma, hypertension (high blood pressure) diabetes and cardiopulmonary disease were offered an annual review of their condition. The practice has also completed an audit of patients using inhalers and their use and advised patients on the use of these during their review.

Data indicated that the practice had a high index of suspected COPD. We discussed this with the practice nurse and the possible reason for this was given as low smoking rates in the population due to cultural reasons and also a young practice population. Asthma clinics were held in line with NICE guidance and a specific template was used to identify and recall patients who required monitoring. The practice nurse offered smoking cessation clinics.

Seventy three percent of patients with hypertension had attended the practice for a review of their condition in the

Good

Are services effective?

(for example, treatment is effective)

last twelve months. Patients with cardiopulmonary disease were offered an annual review and 74% of patients with this condition had been reviewed. Eighty two percent of patients with diabetes have attended an annual review of their condition.

Childhood immunisation rates were discussed with clinical staff and we looked at childhood immunisation data held at the practice. We saw that 90% of eligible babies and children had been immunised, this included immunisation boosters. Patients under the age of five were allocated same day appointments. The practice nurse offered antenatal and postnatal appointments. A midwife from a local hospital attended practice multidisciplinary team meetings once a week. .

The practice invited patients between the age of 40 and 74 for an NHS Health check with the practice nurse. Female patients between the age of 25 and 65 were invited for a cervical smear with the practice nurse. The practice's performance for cervical smear uptake was 81 % which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited female patients records to identify those who had not booked an appointment. The practice had audited the number of inadequate cervical smears and they were at the accepted national average.

A number of students were registered with the practice from a London University which was situated close the practice. The practice had identified physical and health care needs of students as being of a high priority. A counsellor held a session at the practice on Tuesday morning which students could attend. One of the GP partners had a special interest in the treatment of patients for substance misuse. The practice worked closely with a local alcohol and substance misuse project who offered two sessions a week at the practice.

The practice held a register of patients who had learning disability all of whom had received an annual review. We reviewed the care plans of 27 patients on the learning disability register. A register was in place for patients who have an enduring mental health condition. Patients on this register were offered annual health checks including vitamin D testing which the practice introduced after attending a talk on this subject. Seventy per cent of patients diagnosed with a mental health condition had attended the practice for their annual health check. The practice follows up patients who do not attend their annual review and liaises with other mental health services in the social and healthcare sector. Patients who are diagnosed with a mental health condition were invited for an annual review with their GP. Ninety one per cent of patients in this category had attended an annual review and had an agreed and documented care plan in their records.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of 245 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for nurses giving patients enough time during their consultation. Ninety nine percent of patients responded positively to this question in comparison to 85% of patients with the local CCG area. Seventy six per cent of respondents said the last GP they spoke with was good at giving them enough time during their consultation.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 39 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. Patients said that staff at the practice were professional and treated them with respect. GPs were understanding and attentive to their needs and the needs of their family. We also spoke with two 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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

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. Reception and administrative staff had completed training in customer care.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 62 % of practice respondents said the GP involved them in decisions about their care although the national average for involvement stood at 81%.

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. Patients we spoke with gave us examples of how GPs had involved them in their care and explained the treatment process to them.Patients were satisfied with their medical assessment and were referred to secondary health care services where necessary.

Patient feedback on the comment cards we received was also positive and aligned with these views. Patients commented that they had received clear information about their medical condition and how this would affect them, and had their concerns dealt with appropriately. Patients commented on good continuity between the GP and the practice nurse during their medical treatment.

Patient/carer support to cope emotionally with care and treatment

Comments from patients we spoke with and who completed comments cards informed us that staff were supportive and helped then to cope emotionally. Patients gave examples of being supported throughout personally difficult circumstances.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's

Good

Are services caring?

computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them if this was appropriate. Patients who required additional emotional support could be referred to the physiologist who offered sessions at the practice once a week.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We looked at the last survey results completed by the practice and the PPG which took place in October 2013. The PPG met regularly to discuss the results of the survey. Patients had identified making appointments, repeat prescriptions, and access to appointments as an area where they wished to see an improvement. As a result of this the practice had appointed an additional GP and was providing on line booking and prescription request services. The practice also published monthly figures on missed appointments; this information was available for patients.

T**ackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. The practice had identified two groups of patients who required additional services; these were students from a local university and patients with addictions. The practice provided in house counselling for patients who required this and an addiction clinic. The addiction clinic was run jointly by the practice a local substance misuse service.

The practice had access to online and telephone translation services and GPs/nurse who spoke two main languages, English and Arabic, which were identified as the two predominant languages spoken by patients.

The practice was situated on the first and second floors of the building with most services for patients on the first floor. There was lift access to the first and second floors. 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.

Access to the service

Appointments were available from 8:00 am to 7:00 pm Monday to Thursday and 8:00am to 6:30pm on Friday. Home visits were available for older patients and patients who were unable to travel to the practice. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice has a duty rota where one GP was allocated each day to complete a number of routine tasks including offering emergency appointment slots. Other GPs also had allocated emergency consultations slots allocated for each day. When all of emergency appointments have been taken a telephone triage took place to assess the needs of patients. The practice manager and administrative team met weekly to review how appointments had been managed the previous week and plan for the following week.

We looked at the system used for managing patient appointments. Appointment slots were colour coded according to type, for example advance appointments, emergency appointments and telephone consultations. We saw that patients who were identified as being vulnerable were highlighted on the electronic system. For example, patients with mental health needs were allocated an emergency appointment if this was required. This colour coding scheme also applied to other sections of the patient population such as the daily sessions allocated for babies and children.

Patients were generally satisfied with the appointments system although a small number of patients who had been registered with the practice for a number of years commented that the practice list had increased.

Patients felt that this had impacted on the availability of appointments. This was confirmed by staff who had

Good

Are services responsive to people's needs?

(for example, to feedback?)

noticed an increased demand for appointments. Staff informed us plans were being considered to merge with another practice when relocation to an alternative site eventually took place.

We received 39 comment cards completed by patients in the two weeks prior to the inspection. Some patients commented that it was not always possible to get a suitable appointment. Patients commented that the practice was good but the availability of appointments could be increased.

Patients at the practice had responded to the national GP patient survey. Seventy per cent of patients said they were fairly satisfied to very satisfied with the practice opening hours; the local CCG average for this response was 78%. The practice was below the CCG average for patient satisfaction with access to the practice by phone. Forty six per cent of patients answered positively regarding their experience in comparison to 78 % within the local CCG.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system .The practice publicised the complaints procedure in the waiting area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found that these were dealt with in a satisfactory manner. As a result of the complaints GPs were reminded to continue to give patients information leaflets to help patients understand their care and treatment. As a result of a complaint regarding the long wait experienced by a patient GPs aimed to ensure the time allocated for each patient appointment was adhered to.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The vision of the practice was to work in partnership with patients and staff to provide the best primary care services, and to work within local, national and regulatory frameworks. We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. The staff we spoke with commented that they worked in a friendly and supportive environment. Staff identified the need for more space at the practice as an area for improvement.

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 three of these policies and procedures. We spoke with a locum GP who informed us that a full set of practice policies were made available on joining the practice and these were available on the electronically on the IT system.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a nurse for infection control and the management of long term conditions. GP partners led in the area of safeguarding and working with patients who have addictions. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The 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. Clinical staff we spoke with explained how performance and quality management was reviewed in staff meetings. QOF data was regularly discussed and the practice reviewed its performance in line with CCG benchmarking data. The practice had worked within their prescribing budget and was able to demonstrate low referral rates and good management of patients with diabetes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had undertaken four audits in 2014 and was able to demonstrate improvements made to patient care as a result of these. However, out of the four audits we viewed there had been no completed audit cycle.

The practice had arrangements for identifying, recording and managing risks. The practice held monthly clinical governance meetings. We spoke with staff and looked at minutes from meetings. We found that the learning as a result of reviewing good practice as well as identifying risks was not always completed and documented.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We spoke with six staff who worked at the practice. Comments made by staff were that they worked in a friendly and supportive environment. Staff identified the need for more space at the practice as an area for improvement.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) which had steadily increased in size from 28 in 2012 to 35. The PPG included representatives from various population groups. The PPG had carried out annual surveys and met every three months. The practice manager showed us the analysis of the last patient survey which was published in February 2014. As a result of patients views the practice had an action plan which it had implemented. Changes had been made to the provision of GP and nurse appointments. An additional GP had joined the practice and minor illness appointments had been made available with the practice nurse. Software had been purchased to enable patients to make on line appointments and request repeat prescription. The results and actions agreed from these surveys were available on the practice website.

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 two staff files and saw that

Are services well-led?

Good

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

regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and they were able to raise concerns and attend peer group meetings.

The practice had recorded and made changes to practice as a result of significant events and incidents. However, the practice not reviewed significant events and incidents and incorporated learning from these into discussion at staff meetings.