82 Lillie Road - Dr Harrop-Griffiths and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Surgery – 82 Lillie Road provides primary medical services to approximately 7,500 patients in Fulham, in the London borough of Hammersmith and Fulham. This is the only location operated by this provider.

We visited the practice on 3rd October 2014 and carried out a comprehensive inspection of the services provided.

We rated the practice as 'Outstanding' in the responsive domain and Good' in the other four domains we inspected - safe, effective, caring, and well-led. We also rated them 'Good' for the care provided to all six population groups we looked at including older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia)

Our key findings were as follows:

- Arrangements were in place to ensure patients were kept safe. The practice learnt when things went wrong and shared learning with all staff to minimise the risk of reoccurrence
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice.
- We saw from our observations and heard from patients that they were treated with dignity and respect.
- The practice understood the needs of their patients and was provided services that met their needs.
- The practice was well-led, had a defined leadership structure and staff felt supported in their roles.
- Pre-bookable Saturday morning appointments were available for patients who may have difficulty attending during weekday opening hours

Summary of findings

- GP's at the practice attend the local Multi-Agency Safeguarding Hub (MASH) to improve the safeguarding response for children and vulnerable adults through better information sharing and timely safeguarding responses

We saw areas of outstanding practice including:

- The practice was open from 7 .00am to 7.30pm Mondays and Thursday, 7.00am to 5.00pm on Fridays and from 8.30am to 11.30am on Saturdays.
- The practice had a community psychiatric nurse based there once a week to manage care plans of patients experiencing poor mental health including medication reviews.
- The practice facilitated patients' access to the local Improving Access to Psychological Therapies (IAPT) programme and sign-posted patients to various support groups and organisations including MIND.

However, there were also areas of practice where the provider should make improvements:

- The practice should ensure that all staff who are required to chaperone patients receive the appropriate training.
- The practice should ensure that all non-clinical staff receives training in safeguarding adults.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

GOOD

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. A slot for significant events was on the monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out at the practice annual away day . Staff had received child protection training. Non-clinical staff had not received adult safeguarding training, although most staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults. Appropriate recruitment checks had been undertaken prior to employment for all staff which included checks with the Disclosure and Barring Service (DBS). The infection control lead had carried out audits during the last year and improvements that had been identified for action were completed on time.

Are services effective?

Good

GOOD

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. There was evidence of multidisciplinary working to discuss the needs of complex patents e.g. those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. As the practice was a training practice, doctors who were in training to be qualified as GPs were allocated extended patient appointment times and had access to a senior GP throughout the day for support. The practice offered a full range of immunisations for children, travel vaccines and flu

Summary of findings

vaccinations in line with current national guidance. There was also an in-house counsellor based at the practice one day a week and people with conditions such as mild depression would be offered a course of counselling.

Are services caring?
GOOD

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients 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. GP's told us they would make personal phone calls to families who had suffered bereavement. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and they would be offered grief counselling by the practice's counsellor or signposted to a support service.

Are services responsive to people's needs?
OUTSTANDING

Outstanding

The practice is rated as outstanding 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 these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice reviewed complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. The practice used a telephone translation service and we were told some of the GPs and nurses spoke a second language and could also assist with translation if possible. The premises were accessible to patients with disabilities, for example

Summary of findings

there was street level access to the practice, lift access to the first floor and the toilets were accessible to wheelchair users. The practice registered patients who had 'no fixed abode' such as travellers and homeless people.

Are services well-led?
GOOD

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. The practice proactively sought feedback from staff and patients and this had been acted upon. 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 also noted that team away days were held every annually. The practice had an active patient participation group (PPG). We looked at the results of the in-house annual PPG patient survey and saw that one area looked at was the use of A&E by patients at the practice. As a result the PPG had agreed to produce an information leaflet on appropriate use of A&E services. 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

Good

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 proactive, personalised care to meet the needs of the older people in its population and had a range of specialist services, for example in dementia 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 enhanced needs.

Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly. They also had access to the Older Person Rapid Access Clinic (OPRAC) at a local hospital, which provided same or next-day appointments for assessment of frail older patients. A GP from the practice attended the OPRAC monthly meetings and disseminated information to the rest of the clinical team. A respiratory nurse was also based at the practice for spirometry tests and to manage the care of patients diagnosed with common obstructive pulmonary disease (COPD).

One partner GP visits frail elderly patients or those experiencing mental illness such as depression or dementia who have a high risk of needing hospital care. This is part of a local 'virtual ward' pilot. The aim is to prevent unplanned admissions and support these high-risk patients at home where possible. As part of this there are regular multidisciplinary team meetings reviewing patients and updating care plans.

People with long term conditions

GOOD

Good

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

Summary of findings

practice had GP leads for a variety of chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD) and asthma. One of the practice nurses had received appropriate training to manage and support patients with long term conditions.

Families, children and young people

Good

GOOD

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, health visitors often attended the weekly baby clinic where any safeguarding concerns would be discussed. Immunisation rates were relatively high at 88% 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 and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

GOOD

The practice is rated as good for the population group of the 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 offer continuity of care. The practice was in the process of setting up online services for ordering repeat prescriptions and booking appointments. They offered a full range of health promotion and screening which reflected the needs for this patient group.

The practice had extended opening hours Mondays to Thursday 7.00am – 7.30pm which was useful to patients with work commitments. Feedback from patients confirmed this was happening and felt it was a good idea.

People whose circumstances may make them vulnerable

Good

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

homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 95% of these patients had received a follow-up within a year. The practice offered longer appointments for people with learning disabilities.

One GP partner specialised in drug and alcohol misuse. They had completed parts one of the Royal College for General Practitioners (RCGP) Substance Misuse certificate. This meant they were able to prescribe methadone to patients at the practice. There was also a drug and alcohol counsellor who attended the practice one day a week to support and advise patients with dependency issues.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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

GOOD

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). 80% of people experiencing poor mental health had received an annual physical health check. They regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice ran a weekly clinic that was led by a community psychiatric nurse (CPN) for patients experiencing a mental health crisis. Patients would be supported to access emergency care and treatment at the local hospital if needed.

Patients experiencing poor mental health had also been sign-posted to various support groups and third sector organisations including MIND. They worked closely with MIND who operated a 'virtual ward' to support people with mental health concerns in the community. (Mind is a mental health charity that offers information and advice to people with mental health problems). MIND staff were based at the practice one day a week and they would also escort patients to their hospital appointments.

Summary of findings

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 people with mental health needs and dementia.

There was also an in-house counsellor based at the practice one day a week and people with conditions such as mild depression would be offered a course of counselling.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection and received 12 completed Care Quality Commission (CQC) feedback cards. We looked at the completed CQC comment cards and all but one were very positive about the practice

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care. This was similar to the findings of the latest national GP patient survey which found that 90 percent of respondents described their overall experience of the practice was good and 90 percent said that they would recommend the practice to someone new.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that all staff who are required to chaperone patients receives the appropriate training.

The practice should ensure that all non-clinical staff receives training in safeguarding adults.

Outstanding practice

- The practice was open from 7 .00am to 7.30pm Mondays and Thursday, 7.00am to 5.00pm on Fridays and from 8.30am to 11.30am on Saturdays.
- The practice had a community psychiatric nurse based there once a week to manage care plans of patients experiencing poor mental health including medication reviews.
- The practice facilitated patients' access to the local Improving Access to Psychological Therapies (IAPT) programme and sign-posted patients to various support groups and organisations including MIND.

82 Lillie Road - Dr Harrop-Griffiths and Partners

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 and an expert by experience who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to 82 Lillie Road - Dr Harrop-Griffiths and Partners

82 Lillie Road provides GP primary care services to approximately 7,500 people living in Fulham, in the London borough of Hammersmith and Fulham. The practice is staffed by nine GP's, one male and eight females who work a combination of full and part time hours. The practice is a training practice and employs four trainee GP registrars, two practice nurses, a healthcare assistant, practice manager and four receptionists. The practice holds a General Medical Services (GMS) contract and is commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 7.00 am to 7.30 pm Monday to Thursday, 7.00am to 5.00pm on Friday and 8.30am to 11.30 am on Saturdays. The out of hours services are provided by an alternative provider. The details of the out-of-hours service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website. The practice provides a wide range of services including clinics for asthma, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provides health promotion services including a flu vaccination programme, weekly smoking cessation clinics and cervical screening.

According to the national census data states 60% of the borough's population is white British, 20% white non-British (among which are large French, Polish and Irish communities), 5% black Caribbean, 5% black African with various other ethnicities (including Indian, Pakistani, Bangladeshi and Chinese) making up the remaining 11 percent. Around a third (29%) of children under 16 in Hammersmith and Fulham were classified as living in poverty in 2011, higher than the overall percentage for London (27%) and England (21%). The level of breast screening in the borough is currently the 5th lowest in the country, with close to 4 in 10 eligible women (4,800 women) not having had an NHS screening within the last three years. Cervical screening figures are the lowest in the country for younger women and the 2nd lowest for older women.

Hammersmith and Fulham has the 8th highest population of people with severe and enduring mental illness known to GPs in the country in 2012/13 (2,452 people). Social isolation and loneliness is more common amongst older and vulnerable people in the borough.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit 3rd October 2014. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. They had processes in place for documenting and discussing reported incidents and 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. We saw that following an incident involving a patient attempting to take a blank to prescription, this was immediately reported and procedures were implemented to ensure the pads were always kept secure We reviewed the practices significant events log, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these 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 significant events that had occurred during the last twelve months and these were made available to us. A slot for significant events was on the monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out at the practice annual away day. There was 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 on the practice intranet. Once completed these were sent to the practice manager who showed us the system she used to oversee these were managed and monitored. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us, for example one incident involved the wrong medication being given to a patient after a stay in hospital, as the neurology department had not informed the practice that they had changed the medication. The practice contacted the hospital and implemented a new procedure which involved the hospital informing them when a patient's medication was changed.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. We saw in practice meeting notes that alerts were discussed at practice meetings to ensure all were aware of any relevant to the practice and where action was needed to be taken.

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 children. Clinicians were trained to level three and non-clinical staff were trained to level one. We asked members of medical, nursing and administrative staff about their training and were told that only clinical staff had received training in adult protection.

However, most staff knew how to recognise signs of abuse in vulnerable adults. 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 local authority safeguarding teams were displayed in treatment rooms and notice boards throughout the surgery.

The practice had a dedicated GP appointed as the lead in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. They also attended the local Multi-Agency Safeguarding Hub (MASH) to improve the safeguarding response for children and vulnerable adults through better information sharing and timely safeguarding responses.

All staff we spoke with were aware who the safeguarding lead was 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 patient records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children

subject to child protection plans. We saw that where there had been recent concerns about a patient displaying concerning behaviour towards their children, an alert was put in the records so that staff would observe interaction between the families when they attended the surgery.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of all vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone administration staff had been asked to carry out this role. However, we were told that chaperone training had not been undertaken by these staff and one staff we spoke with did not understand their responsibility when acting as chaperones, including where to stand to be able to observe the examination.

Patient's 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. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. For example one audit had identified that some vulnerable patients care plans had not been updated following annual reviews.

Medicines Management

Medicines were stored in the nurse's treatment room in medicine refrigerators. Whilst the room was only accessible to authorised staff we found there was no lock on the fridge. We were told the practice was about to purchase a new fridge and they would ensure it was lockable. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range. Staff described what action they would take in the event of a potential failure of the fridge.

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.

Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The nurses in the practice were responsible for generating repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times in locked drawers in the nurses office.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept which showed the most areas in the practice was cleaned daily, however the toilets were checked regularly throughout the day and cleaned when needed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and deliver staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the infection control lead had carried out audits during the last year and improvements that had been identified for action were completed on time. For example, we saw that hand washing posters had been replaced at each hand basin where they had been found to be missing.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement infection control 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. For example, staff told us they would always wear gloves to accept specimens from patients. There was also a policy for staff to follow in the event of a needle stick injury.

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.

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 displayed stickers which showed tests had been carried out in July 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors and ultrasound machines.

Staffing & Recruitment

Staff records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all staff. For example, proof of identification, references, 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 followed when recruiting clinical and non-clinical staff.

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 ensure patients were kept safe. There were procedures to follow in the event of staff absence to ensure smooth running of the service. The practice manager occasionally provided cover in reception to ensure there was never one member of administration staff working alone during busy periods.

Monitoring Safety & Responding to Risk

There were 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 which staff were required to read as part of their induction which was accessible on the intranet for all staff. One GP at the practice was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk log maintained by the practice. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example a recent risk assessment had identified that there were electrical wires in some offices that posed a risk and an electrician had been booked to attend the practice to reduce the amount of wires. Staff also told us they would salt and grit the path leading to the surgery when it snowed or was covered in ice.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health. For example the practice kept a register of vulnerable patients which provided alerts to staff to follow up on attendance and results when patients in this group where referred for tests and medical procedures. This ensured they were able to inform GP's when patients had not attended for tests.

The practice ran a weekly clinic that was led by a community psychiatric nurse (CPN) for patients experiencing a mental health crisis. Patients would be supported to access emergency care and treatment at the local hospital if needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff had received training in basic life support which was updated every two years. Oxygen was available on site. All staff asked knew the location of this equipment and records we saw confirmed it was checked regularly. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) however a full risk assessment had been undertaken and a protocol was in place to manage this, for example dial 999 and call an ambulance.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This covered areas such as long or short term loss of access to the building, loss of the computer system, loss of access to paper medical records, loss of the telephone system, incapacity of GPs and loss of water, gas and electricity supply. Each risk was rated and mitigating actions recorded to reduce and manage the risk. 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. The plan was reviewed every year at the practice away day.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. For example we saw it had identified that fire drills should be carried out at least annually and we saw that one had occurred in August 2014. We saw records that showed staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw the practice had weekly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The GPs told us there was a lead for all specialist clinical areas such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease (COPD). The practice nurses supported this work, for example a nurse had attended additional training for diabetic care. GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. Review of the clinical meeting minutes confirmed that this occurred. For example we saw the practice had recently received guideline on management and prevention Pressure Ulcers. As a result the practice had decided to send their nurses on refresher courses.

The senior GP partner showed us data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which showed the practice was achieving its targets in all areas identified by the CCG, which were quantity of anti-biotics prescribed, using first line anti-biotics and quantity of NSAIDs used. They were performing better than similar practices in the area. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. Patients who were on care plans would be offered appointments within two weeks of discharge according to need.

Practice data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All referrals made were reviewed by a senior GP to ensure that they were appropriate and directed to the correct service. We saw that some referrals were rejected with explanations of why the referral was not appropriate. The practice held regular review of elective and urgent referrals made. We observed a clinical meeting where a random selection of referrals made to the ear, nose and throat department within a selected time frame were reviewed. We saw that improvements to practise were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us ten clinical audits that had been undertaken in the last year. Six of these were completed audits i.e. the practice had re-audited. The practice was able to demonstrate the changes resulting since the initial audit. For example a HIV drug interactions audit reviewed all patients on anti-retroviral medication for possible drug interactions. As a consequence of the cycle of audits undertaken all patients diagnosed with HIV now had a clinical alert in their records and updated drug interactions recorded.

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 national performance measurement tool. For example we saw an audit regarding the prescribing non-steroidal anti-inflammatory drugs (NSAIDS). Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 70% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (COPD). This practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement. All clinical staff undertook at least one audit per year. For example one GP was currently auditing Mental Health referrals in 2014. The practice had reflected on their referral patterns and assessed common pitfalls to enable patients to be managed in the most appropriate way. This audit cycle is due to be completed in 2015.

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 prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it recorded the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had 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. For example, the practice was amongst four out of 20 practices that were achieving the CCG target for the prescribing of first line antibiotics.

Effective staffing

The practice staff team 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. A good skill mix was noted amongst the doctors with one doctor having additional diplomas in diabetic management and one other trained to administer methadone medication. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and 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).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff we spoke with confirmed that the practice was proactive in providing training and funding for relevant courses. For example, a receptionist had been supported to attend a health care assistant course. As the practice was a training practice, doctors who were in training to be qualified as GPs were allocated extended patient appointment times and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example seeing patients with long-term conditions such as diabetes. The nurses were able to demonstrate they had appropriate training to fulfil these roles.

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 hour's 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 actioning any issues arising from communications with other care providers on the day they were received. The GP reviewing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents e.g. those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. There was also an in-house counsellor based at the practice one day a week and people with conditions such as mild depression would be offered a course of counselling.

Good

Are services effective?

(for example, treatment is effective)

The practice worked closely with MIND who operated a 'virtual ward' to support people with mental health concerns in the community. (Mind is a mental health charity that offers information and advice to people with mental health problems). MIND staff were based at the practice one day a week and they would also escort patients to their hospital appointments.

We saw evidence that the practice liaise regularly with midwives, health visitors and school nurses where they had concerns. For example we saw they would contact school nurses when children missed a number of immunisations appointments and were of school age.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff however told us they encountered a number of difficulties with this system and often arranged hospital appointments manually via the phone, fax or emails. A record of each referral including the sent date was maintained on a spreadsheet by the administration staff to monitor for any delays. Urgent two week referrals for suspected cancer symptoms that need to be investigated urgently were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

Patients who required emergency assessment in hospital would be provided with a printed copy of a summary record for the patient to take with them to A&E, or it would be given to the ambulance crew if the patient was taken from the practice by ambulance.

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.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in relation to assessing a person's capacity to give consent. Clinical staff had received training on the Mental Capacity Act 2005. 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. For example one GP told us how they had carried out a capacity assessment for a patient who had learning disabilities and was refusing treatment. As a result they had involved their carer in the discussion and decision.

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. The practice kept a register of these patients to help ensure they received the required health checks. These patients were offered annual review appointments with their carers during which they would be supported in making decisions about their care plans.

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).

Health Promotion & Prevention

All new patients who registered with the practice were offered a health check with the practice nurse within a week of registering. The GP was informed of all health concerns detected and these were followed-up in a timely manner. GPs told us they would use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 40% of patients in this age group took up the offer of the health check. The practice manager said they did not actively chase up the ones that did not attend, but would opportunistically discuss the check when patients attended the surgery for routine appointments.

The practice ran a weekly smoking cessation clinic on Mondays. Referrals to the service were made by the GP's, however patients' could also self-refer. Information about the service was available in the waiting area. The service offered a 12 week programme to assist people in successfully stopping smoking. They however did not have any data to show how effective this had been.

Good

Are services effective?

(for example, treatment is effective)

Cervical screening was offered to woman in line with the national guidelines. The cervical screening uptake rate was approximately 70% for the year 2013 which was better than other GP practices in the Clinical Commissioning Group (CCG) area. The practice sent text message reminders for patients and would follow up patients who did not attend for cervical smears. There was a named nurse responsible for following-up patients who did not attend for cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was approximately 85% which was above average for the CCG, however the practice stated they were continually trying to improve their vaccination take up rates.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed staff to be caring, and compassionate towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice staff and that they treated them with kindness and respect.

Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 12 completed cards and the majority were positive about the service experienced. Patient felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There was one comment that was less positive as they felt the surgery should offer weekend emergency appointments. 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.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from July 2014 and a survey of 189 patients undertaken by the practice's Patient Participation Group. (A selection of patients and practice staff who meet at regular intervals to decide ways of making a positive contribution to the services and facilities offered by the practice to the patients.) 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 patients rating the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 80% saying the GP gave them enough time compared to the national average of 80% and 74% respectively..

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

We 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. We saw that when patients wanted to speak with reception staff in private they were taken into a side room or up to the practice manager's office.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us that any concerns raised would be investigated and any learning identified would be shared with staff. We were shown an example of a report of a recent incident that showed the actions taken in response to an allegation of discrimination had been robust. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey from July 2014 showed 88% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. compared to the national average of 81% and 84% respectively

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.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this feedback. For example, patients described that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also signposted 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 to ensure they understood the various avenues of support available to them.

GP's told us they would make personal phone calls to families who had suffered bereavement. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and they would be offered grief counselling by the practice's counsellor or signposted to a support service. Staff told us they would also attend the funerals of patients on occasions. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice worked closely with the palliative care nursing team and held quarterly meetings with them. Deaths of patients were discussed at the monthly practice team meetings.

Outstanding ☆

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 the needs of their local population. The practice attended a monthly network meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease, substance dependency and mental health.

Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly. They also had access to the Older Person Rapid Access Clinic (OPRAC) at a local hospital, which provided same or next-day appointments for assessment of frail older patients. A respiratory nurse was also based at the practice for spirometry tests and to manage the care of patients diagnosed with common obstructive pulmonary disease (COPD).

One partner GP visits frail elderly patients or those experiencing mental illness such as depression or dementia who have a high risk of needing hospital care. This is part of a local 'virtual ward' pilot. The aim is to prevent unplanned admissions and support these high-risk patients at home where possible. As part of this there are regular multidisciplinary team meetings reviewing patients and updating care plans.

The practice had registers for patients who needed palliative care, had complex needs or had long term conditions. They had regular internal as well as multidisciplinary meetings to discuss patients and their family's care and support needs. Patients in these groups would be allocated longer appointment times when needed. As a consequence of a better understanding of the needs of patients, the practice had increased the number of patients on the register as patients and other professionals recommended their practice. Records we looked at showed the patient size had been steadily increasing over the last few years and that most of the new patients were older people. We saw evidence that the list size was steadily increasing.

One GP partner specialised in drug and alcohol misuse. They had completed parts one of the Royal College for General Practitioners (RCGP) Substance Misuse certificate. This meant they were able to prescribe methadone to patients at the practice. There was also a drug and alcohol counsellor who attended the practice one day a week to support and advise patients with dependency issues.

The practice had a community psychiatric nurse based there once a week to manage care plans of patients experiencing poor mental health including medication reviews. They ran a drop in session, supported people coming out of hospital to integrate back into the community and provided injections of anti-psychotic medication to people stabilised on this medication. Patients who experienced poor mental health were kept on a register and invited for annual reviews with extended appointments. Reception staff we spoke with were aware of signs to recognise for patients in crisis and to have them urgently assessed by a GP if presented.

The practice facilitated patients' access to the local Improving Access to Psychological Therapies (IAPT) programme and sign-posted patients to various support groups and organisations including MIND. The practice monitored repeat prescribing for people who received medication for mental health needs. 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. When information was received from the hospital regarding someone with a mental health condition, the practice would try to contact with the person either directly or through contacting a MIND worker or the community mental health teams.

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, they had changed the telephone answering system to ensure the phone was always answered and that people were not put on hold for more than two minutes.

Tackle inequity and promote equality

We were told by staff that a high proportion of the practice population did not speak English as their first language. The practice used a telephone translation service and we were told some of the GPs and nurses spoke a second language and could also assist with translation if possible.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The premises were accessible to patients with disabilities, for example there was street level access to the practice, lift access to the first floor and the toilets were accessible to wheelchair users.

The practice registered patients who had 'no fixed abode' such as travellers and homeless people. The process for registering would be the same as other patients however 'no fixed abode' would be placed in the address line on the system.

We saw that the practice had recognised the need for equality and diversity training for its staff and had arranged for the training to be carried out with other local practices in their network. Staff we spoke with confirmed that they had had discussions in practice meetings about equality and diversity issues and that it was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 7 .00am to 7.30pm Mondays to Thursday, 7.00am to 5.00pm on Fridays and from 8.30am to 11.30am on Saturdays. The telephones were manned during opening hours and a recorded message was available at all other times. Appointment slots were available throughout the opening hours, except between 12.30 and 1.30 daily, when the practice was closed for lunch.

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 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.in the practice information leaflets and on the website.

There was a duty doctor available daily to see emergency appointments between 7am and 11am and 3.30pm - 5.30pm. Patients were generally satisfied with the appointments system. 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. All patients we spoke with told us they had always been able to get an emergency appointment and if they had not been able to see the doctor the same day, they said they were able to talk with them on the phone. .

The practice opened 7.00am – 7.30pm Monday to Thursday which was useful to patients with work commitments. Feedback from patients confirmed this was happening and felt it was a good idea.

The practice was situated on the ground and first floors of the building with the majority of services for patients on the ground floor. Lift access was provided to the first floor. 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.

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. The practice manager was the designated person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way in line with the complaints policy. We saw that when complaints could not be resolved in house or where patients were unhappy with the outcomes, they had contacted the Parliamentary and Health Service Ombudsman. This had happened in one case that we looked at.

The practice reviewed complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon. For example where a patient had

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

complained about not being supported appropriately when making a sensitive decision about their treatment. The surgery had implemented a system where by patients in similar circumstances now would be offered to be referred to a counsellor. We were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all staff.

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. Details of the vision and practice values were part of the practice's annual business plan. The practice vision and values included 'to provide the best possible quality care for patients within a confidential and safe environment , to focus on prevention of disease by promoting health and wellbeing, offering care and advice to patients and to be a learning organisation that continually improves what the practice is able to offer patients.'

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice away day held in 2014 and saw that staff had discussed and agreed that the vision and values were still current.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We saw that staff had completed a cover sheet to confirm they had read the key policies such as safeguarding, health and safety and infection control. All ten policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings which were attended by the partners and the practice manager. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. There was a clinical lead for the different areas of the QOF and we saw an action plan had been produced to maintain or improve outcomes. We saw QOF data was regularly reviewed and discussed at the practices monthly meetings.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review which took place in September 2014, which showed that the practice had the opportunity to measure their service against others and identify areas for improvement. For example the need to reduce the numbers of patients presenting to A&E instead of visiting the GP.

The practice had completed a number of clinical audits, for example a digoxin audit was carried out after there was some concern expressed about its toxicity when patients were taking other medications. All patients on digoxin were reviewed. Urea and Electrolytes (U&E) levels had been tested and recorded for 91% of relevant patients and the remaining patients were contacted to have blood tests. This audit helped to raise awareness of digoxin toxicity as a possible cause for confusion, nausea, vomiting. The audit cycle was completed through a re-audit in June 2014 and the results had improved. There is now a clinical alert for patients on Digoxin when their record is opened.

The practice had robust arrangements for identifying, recording and managing risks. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. The management of pressure sores, and risks associated with inserting catheters had been discussed at a recent meeting.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and one of the senior partners was the lead for safeguarding. We spoke with seven 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 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 annually.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, and management of sickness which were in place to support

Are services well-led?

Good

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

staff. We were shown the staff handbook that was available to all staff, this 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 an active patient participation group (PPG) which met quarterly. The PPG included representatives from various population groups; including working age people, older people, carers and patients from different ethnic and cultural backgrounds.

The practice had gathered feedback from patients through PPG patient surveys, comment cards and complaints received. We looked at the results of the in-house annual patient survey and saw that one area looked at was the use of A&E by patients at the practice. Forty five percent of patients said they had used A&E recently. Although some stated the reason was because they were unwell outside surgery opening hours, a proportion stated that they were unaware of the surgery opening hours. The survey highlighted the fact that not all patients were aware of the services the practice offered or their opening hours. We saw as a result of this the PPG had agreed to produce an information leaflet on appropriate use of A&E services and when to attend, including information about the surgery opening hours, services on offer and seeing a doctor for an emergency.

The practice had gathered feedback from staff via staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy and the process to follow if they had any concerns

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that guest speakers and trainers often attended the practice. For example, a dementia consultant had recently attended the practice to talk about dementia care and referrals. This had led to an increase in early referrals for suspected dementia.

The practice also held weekly learning sessions for clinicians. These often occurred on a Friday where the clinicians would have an extended lunch and various clinical issues were discussed. For example on the day of our visit we observed the session which looked at an audit of ENT referrals in which all referrals in a selected time frame were reviewed by the clinical team to assess whether patients had been appropriately referred to secondary care and if not, what lessons could be learned for future referrals.

One member of staff told us that they had asked for health care assistant training and this had occurred. The practice was a GP training practice and at the time of our visit there were four trainee GP registrars.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings and away days to ensure the practice improved outcomes for patients. For example, a district nurse had been unable to administer appropriate medication to a patient who was housebound, as they had not collected the medication chart from the practice, therefore there was no information about what medication the patient should receive at their home. As a result a system had been put in place to ensure that such an incident was not repeated and that medication charts were delivered to a patient's home when needed.

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.

This section is primarily information for the provider

Enforcement 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.