

Dr Tahalani and Partners

Quality Report

Southgate Road Medical Centre,
101-103 Southgate Road
London N1 3JS

Tel: 020 7704 2233

Date of inspection visit: 18th February 2015

Website: www.southgateandwhistonpractice.nhs.uk Date of publication: 06/08/2015

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?

Good 

Are services effective?

Requires improvement 

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	7
What people who use the service say	10
Areas for improvement	10

Detailed findings from this inspection

Our inspection team	11
Background to Dr Tahalani and Partners	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Talahani and Partners on 18th February 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, caring, responsive and well-led services, however some improvements were required for effective. It was also good for providing services for the care provided to 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. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses

- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice guidance.
- We saw from our observations and heard from patients that they were treated with dignity and respect and all practice staff were compassionate.
- The practice understood the needs of their patients and was responsive to them. There was evidence of continuity of care and people were able to get urgent appointments on the same day.
- There was a culture of learning and staff felt supported and could give feedback and discuss any concerns or issues with colleagues and management

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

- The practice should ensure that all staff that act as chaperones receive chaperone training.
- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.

Summary of findings

- The practice should ensure all staff receive training on infection control.
- Ensure completed clinical audit cycles are undertaken.
- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.

- The practice should ensure they have a clear leadership structure that all staff are aware of.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services. 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 and staff told us 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 annually. All staff had received child protection training and although non-clinical staff had not received adult safeguarding training non clinical staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults and were clear about how to report concerns. Administration staff had been asked to carry out chaperone duties without appropriate training, however staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination.

An infection control audit had been carried out during the last year and improvements that had been identified were included in an action plan and completed on time.

Good



Are services effective?

The practice is rated as requires improvement for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's capacity to make decisions and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out staff appraisals and had established personal development plans for staff. There was evidence of multidisciplinary working to discuss the needs of complex patients especially those on care plans. These meetings were attended by district nurses, community matrons, care coordinators and decisions about care planning were documented in a shared care record. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

We did however find that although the practice had a system in place for carrying out clinical audit cycles they did not have any completed audits to drive improvement in patient outcomes.

Requires improvement



Summary of findings

Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others in the borough for several aspects of care. Patients said they were treated with respect, dignity and compassion and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Patients who had care plans had annual reviews or more frequently where needed.

We saw that staff treated patients with kindness and compassion ensuring confidentiality was maintained. Patients told us the care was excellent and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback from the CQC patient comment cards we received was also positive and aligned with these views. Clinicians told us they would make phone calls to families who had suffered bereavement, offer to refer them to appropriate services for support and attended funerals of their patients.

Good



Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with Clinical Commissioning Group (CCG) to secure service improvements where these were identified. All vulnerable patients had a named GP. There was evidence of continuity of care and people were able to get urgent appointments on 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 in a timely manner. The practice used a telephone translation service but the GPs spoke most of the languages used by their patient population. Both premises were accessible to patients with disabilities as the surgeries were on the ground floor. Toilets were accessible to wheelchair users.

Good



Are services well-led?

The practice is rated as good for being well-led. Although there was a need for a clearly documented vision which all staff were aware of, the staff felt the vision was to give a good service, good treatment and care and to respond to concerns; however this was not documented.

Good



Summary of findings

High standards were promoted and owned by all practice staff and teams worked together across all roles. There was governance arrangements in place, however there was a need to ensure that a clear leadership structure was in place. Staff felt supported by management who had a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients and that there was a culture of learning.

The practice gathered feedback from patients through an internal patient survey organised by their patient participation group (PPG), who met quarterly and we saw changes made as a result of feedback from this group.

Summary of findings

The six population groups and what we found

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

Older people

The practice used a risk profiling tool which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The practice was signed up to both the Avoiding Unplanned Admissions (AUA) enhanced service and a 'frail home visiting' enhanced service. The aim of both of these services was to target care to those most at risk of hospital admissions. Both services identify vulnerable, elderly patients and necessitate enabling named clinician-led care, developing a care plan, proactive management and home visiting of elderly patients. The practice kept a register of elderly patients whose care needed to be prioritised. This register was accessible to reception staff and enables them to be proactive in providing care for these patients. The practice had been allocated a 'Care coordinator' to help to meet the non-medical needs of this group of patients by liaising with external agencies and dealing with issues such as housing and finance. Multi-disciplinary monthly meetings were held to review complex cases. These were attended by community matron, district nurses and the care coordinators. The GP's told us this approach helped to promote holistic patient care.

Good



People with long term conditions

The practice was signed up to City and Hackney long term conditions enhanced service for conditions such as diabetes, asthma and COPD. This encompassed both prevalence targets and management targets. The GPs felt that combined with QOF this meant they had to be proactive in identifying patients with long-term conditions and optimising their care. They had a recall system set up where each lead clinician was allocated a specific administrator who recalled patients for annual reviews. Recall lists are printed off weekly and recalls were managed via phone, letters and texts. All attempts at contact was documented in the patients records. Non-responders are followed up opportunistically. In some cases, repeat medication can be changed to 'Acute' with a prescription reminder to both patient and pharmacist to encourage review with a GP. Diabetes specialist nurse clinics were held twice per week, together with diabetes dietician clinics, and a heart failure specialist nurse who visited patients at their homes. In addition, practice nurses and HCAs regularly undertook reviews for Asthma, COPD, hypertension and diabetes.

Good



Summary of findings

Families, children and young people

We saw evidence that the practice have monthly health visitor meetings where they discussed children in need and complex cases. They maintained a register of vulnerable patients and see walk-in emergencies at both sites and in every clinical session. The GPs demonstrated an understanding of Gillick competency and we saw evidence of them seeing the under 16's in their clinics. The practice worked closely with the sexual health clinic, the Ivy centre, which was based in the same site as one of their branch surgery. The nurse prescriber had additional training in contraception and gave advice to women and was able to give repeat prescriptions for contraception. This removed the need for patients to have a GP appointment.

There were weekly immunisation baby clinics and last year's performance for child immunisations at age 12 months was approximately 95% which was higher than the CCG area average of 85%.

Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. Clinicians offered family planning advice, fitted IUDs and prescribed the contraceptive pill.

Good



Working age people (including those recently retired and students)

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 offered continuity of care. They had extended opening three days a week and online services for ordering repeat prescriptions, booking appointments and getting test results were available. They also offered phone consultations for patients who could not attend the surgery. The practice offered an extensive range of health promotion and invited patients over 40 years of age to have an NHS health check

Good



People whose circumstances may make them vulnerable

The practice's two surgeries are located in areas where a large amount of their patients are socially deprived and have difficulty accessing both medical and social support. The practice therefore offers services to meet their patients 'holistic' needs, such as a

Good



Summary of findings

weekly benefits advisor attends the practice on Friday mornings and a family action counsellor' attends on Thursday mornings. We saw their system diary which confirmed these sessions were well attended.

One of the GPs was the lead for vulnerable adults and reception staff had a list of vulnerable patients to ensure they were prioritised for appointments. 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.

Practice staff had access to an interpreter and translation service via language line to ensure that those patients whose first language was not English could access the service. The practice was accessible to disabled patients

People experiencing poor mental health (including people with dementia)

The practice worked closely with link consultants from the local Community Mental Health team (CMHT) who attend the practice quarterly to discuss clinical cases, namely people who had been transferred back to primary care from secondary care. We saw notes from these meetings were typed directly into patient's records. The practice had an allocated mental health liaison nurse who assesses appropriate patients in the practice and also attends the CMHT meetings. We saw the practice works very closely with primary care psychology services – IAPT and they refer patients to the Tavistock clinic, who provides in-house psychotherapy services when needed.

We saw evidence that both clinical and administrative staff have had Mental Capacity Act and dementia awareness training. QOF data showed the practice had scored 100% for conditions commonly found amongst older people such as dementia.

Good



Summary of findings

What people who use the service say

We spoke with 9 patients during our inspection and received 42 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were 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. Patients said the care was good and staff were friendly, professional and accommodating and that all staff treated them with dignity and respect.

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 partner GPs gave consistently good care. The national GP patient survey found that 86% of respondents described their overall experience of the practice as good and 70% 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 that act as chaperones receive chaperone training.
- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.
- The practice should ensure all staff receive training on infection control.
- Ensure completed clinical audit cycles are undertaken.
- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.
- The practice should ensure they have a clear leadership structure that all staff are aware of.

Dr Tahalani 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 Dr Tahalani and Partners

Dr Tahalani and Partners provides GP primary care services to approximately 6,200 people living in Islington and Hackney. They have two branch surgeries namely Southgate Medical Center and Whiston Road surgery and patients can choose which surgery they wish to attend for appointments. The practice is staffed by four GPs, three male and one female who work a combination of full and part time hours. The practice employs one nurse, a HCA phlebotomist, a practice manager and seven administrative staff. The practice holds a General Medical Services (GMS) contract and was 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 9am to 7pm Monday, Tuesday, Wednesday and Fridays and 9am to 2pm on Thursday. The practice offers extended hours appointments at both sites: Monday evening (Whiston road), Tuesday evening (Whiston road) and Wednesday

evening (Southgate road) where the practice would be open until 7.45pm. The practice had recently signed up for a new locally enhanced service which will incorporate further extended hours.

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 closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

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, travel vaccinations and cervical screening.

Both surgeries are located in areas where a large amount of their patients are socially deprived and have difficulty accessing both medical and social support. The practice therefore offers services to meet their patients 'holistic' needs, such as a weekly benefits advisor and a family action counsellor. The practice patient population has a mixed ethnic profile; 40% white British, 10% Asian from background, 28% from Black/ African/Black Caribbean and 22% other ethnic backgrounds.

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.

Detailed findings

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 on 18th February 2015 to both sites. During our visit we spoke with a range of staff (doctors, practice manager and administrative staff.) and spoke with patients who used the service. We reviewed policies and procedures, patient treatment records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve 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. All staff were encouraged to log any significant event or incident and we saw there was a template for this that was accessible on all computer desk tops. Staff we spoke with were aware of their responsibilities to bring them to the attention of the practice manager. The practice manager was responsible for investigating non-clinical incidents and the lead GP would investigate clinical incidents. These were usually discussed on the day they occurred. Action points were then circulated to all staff. We saw that at a recent practice meeting they had discussed a case where the wrong vaccine had been given to a patient. The practice nurse had contacted the health department and took advice and then made contact with the patient to discuss what had happened, advice regarding the options available to them and to provide appropriate support.

We reviewed safety records, incident reports and minutes of meetings from August 2014 where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw evidence to confirm that the practice completed a significant event analysis (SEA) annually which included identifying any learning from the incident. For example, we saw a learning point from the above incident was the practice had identified that both medications came in similar bottles and as such should not be stored next to each other in the fridge and both should be clearly labelled. They also instructed that nurses should double check vaccines before giving them to patients. SEA's were discussed with all staff at the monthly practice meetings.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with told us of a recent alert they had discussed that had been circulated by the CCG regarding missing children who were

the subject of safeguarding arrangement. They also told us that alerts were discussed at monthly practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers.

The practice had systems in place 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 safeguarding training and were told that only clinical staff had received training in adult protection. However, most non clinical staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located in safeguarding intranet pages and displayed on the walls of the treatment rooms and the practice manager's office.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic patient records. This included information so that staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with

Are services safe?

partner agencies such as the police and social services. The safeguarding lead attended child protection case conferences and reviews where appropriate and reports were sent if staff were unable to attend.

A chaperone policy was in place and there were visible notices 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 members although staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff with chaperone duties had been DBS checked. Since our inspection we have received evidence to confirm that all relevant staff have now completed Chaperone training.

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.

Medicines management

Medicines were stored in medicine refrigerators in one of the nurse's treatment room. 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 procedure to follow if temperatures were outside the recommended range and staff were able to describe 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.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The practice nurse was 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 room. The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

We were told the nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance, although we did not see any on the day of our inspection, however we have subsequently seen evidence of these. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber, we saw evidence to confirm this. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed which was the contraceptive pill.

GPs reviewed their prescribing practices as and when medication alerts were received. We saw that GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to keep abreast of updated medication information.

Cleanliness and infection control

We observed the premises were clean and tidy although we did find some high level dust on the cupboards in one of the surgeries. Cleaning of the premises was carried out daily by a contract cleaner that was employed by the practice. Cleaning records were kept which showed a list of what had been cleaned at each visit. Reception staff told us that 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 carry out staff training. Staff had not received training on infection control, however we saw evidence to confirm it had been

Are services safe?

booked. Since our inspection we have received evidence to confirm that all staff have now had the training. An infection control audit had been carried out in July 2014 by NHSE which had identified the need to have a written cleaning log and schedule which had been actioned as a cleaning log was available for our inspection. An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they would always wear gloves to accept specimens from patients as stated in the infection control policy.

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

The practice had a 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 that the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

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 January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter.

Staffing and recruitment

The practice had a recruitment policy in place which was up-to-date. Appropriate pre-employment checks were completed for staff before they started work at the practice. We looked at a sample of recruitment files for GPs, administrative staff and nurses and found they contained proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

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 during busy periods.

The GP partners and practice manager told us about the arrangements for planning and monitoring the number 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. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

The lead GP told us they had recently reviewed the staffing levels and skill mix and had identified a need to increase their GP's and had appointed another salaried GP.

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 which staff were required to read as part of their induction which was accessible on the intranet for all staff. The practice manager 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 manager with clear actions required and date to be completed clearly noted. We saw that any risks were discussed at GP partners' meetings and within team meetings.

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 were referred for tests and medical procedures. This ensured they were able to inform GP's when these patients had not attended for tests.

Arrangements to deal with emergencies and major incidents

Are services safe?

The practice had arrangements in place to manage emergencies. Oxygen cylinders were available at both sites. All staff asked knew the location of this equipment and records we saw confirmed they were checked regularly. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and had not carried out a risk assessment to identify what action would be taken in an emergency.

Staff told us they had training in basic life support including cardiopulmonary resuscitation (CPR) and other emergencies such as fire and floods. Staff records showed all staff had received training which was updated every two years.

Emergency medicines were available and were kept in the practice managers office at one site and in the HCA's office at the other site 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 the main premises, loss of the computer system/essential data, loss of access to paper medical records, loss of the telephone system, incapacity of GPs and loss of supplies. The document also contained relevant contact details for staff to refer to. For example, contact details of utility suppliers, all staff contact numbers and email addresses and contact details for locum doctors. The plan was reviewed on an annual basis.

A fire risk assessment had been undertaken that included actions required to maintain fire safety.

For example we saw it had identified fire alarm tests should be carried out every week and that fire drills should occur at least every year. We saw records to confirm the alarm had been tested weekly and fire drills were carried out annually and the last one had occurred in April 2014. We saw records that staff were up to date with fire training.

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 (NICE) 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 and nurses told us staff completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines..

The GPs told us there was a lead for all specialist clinical areas such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD). One practice nurse also had additional training in women's health and was able to prescribe the contraceptive pill. GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. Review of the nurse meetings and clinical meeting minutes confirmed that this occurred. For example we saw they had recently discussed new guidelines relating to Hypertension and the practice had identified where improvement can be made. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes, which was approximately two percent of the practice patients. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need. Discharge summaries were sent to the practice manager who would liaise with the relevant GP to book an appointment, either at the surgery or the patients' home.

We saw they had carried out a review of their cancer referrals and compared their own performance with other local practices. They found their referral rates lower than

other practises and as a result had a meeting with the cancer advisor from the CCG in order to review their referral criteria to ensure they were following the CCG guidelines and agree how this could be improved.

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 cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Patients told us they had never experienced any discrimination at the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for carrying out clinical audit cycles. However, they did not have any completed audits i.e. the practice had not re-audited. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. QOF is a national performance measurement tool. For example, one GP had started an audit monitoring Opioid prescribing that had started in the last year. They had identified the patients who were currently being prescribed Opioids and had looked at the length of time they had been prescribed this medication and invited them in with a view to reducing the number of people who may have become dependent and as a result may misuse, abuse, or overdose from these powerful drugs, whilst ensuring they had effective treatment to manage their pain. A re-audit was due to take place in March 2015. We noted however that some clinical staff were not aware that the audit was taking place.

GPs told us they were committed to maintaining and improving outcomes for patients.

The QOF report from 2012-2013 showed the practice scored 918 out of 1000. QOF information for 2013-2014 indicated the practice had improved significantly scoring 888 out of 900. Clinical staff spoke positively about the culture in the practice around quality improvement.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP's. They also checked that all routine health checks were completed for long-term conditions such as asthma 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

Are services effective?

(for example, treatment is effective)

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

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.

Representatives from the CCG routinely attend the monthly meeting and feedback on areas where there is an increase in the trend for referrals and/or areas of increased spends for prescribing. This benchmarking data showed the practice had outcomes that were similar to other services in the area for prescribing.

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. 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 General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

The staff induction programme covered a range of topics such as basic lifesaving and child protection. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to both develop them and ensure they had the knowledge and skills required to carry out their roles. For example, all staff had received consent and dementia training, reception staff had received information governance training, and the practice manager had completed a leading and motivating course.

Non-clinical staff told us they had regular opportunities to hold discussions about their work during the week, as the practice manager operated an 'open door' policy. All staff received annual appraisals which identified learning needs. Non-clinical staff were appraised by the practice manager and clinical staff were appraised by one of the partners. Staff records demonstrated that appraisals were up to date. We saw performance and personal development were discussed at these meetings. There were arrangements in place to support clinical staff through the revalidation process. For example the salaried GPs were supported to attend study days in regards to any updates in key aspects of their role such as prescribing mental health medication.

Staff we spoke with confirmed that the practice was proactive in providing training and funding for development courses. For example, the HCA had been trained to give flu jabs and B12 injections.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

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 out of hour's providers, the NHS 111 advice service and local hospital including discharge summaries were received electronically. All relevant staff were aware of their responsibility for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The practice manager circulated the documents and results to the relevant GPs who were responsible to carry out the action required. All staff we spoke with understood their roles and felt the system in place worked well. We were told here 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 patients e.g. those with end of life care needs. These meetings were attended by community matrons, 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. The GPs told us that they would often have ad hoc discussions outside of these meetings when they had serious concerns about patients

Are services effective?

(for example, treatment is effective)

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. An electronic system was also in place for making referrals for tests or to see specialists and staff 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 were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, 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. All 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 might use it in their practice. For example, one GP told us they would apply the Act if they had concerns about an older person with Dementia in relation to 'end of life' care arrangements.

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).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this.

Health promotion and 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 they would take a patients' blood pressure and on occasions had offered opportunistic diet and nutrition advice.

The practice also offered NHS Health Checks to all patients aged 40-75 without a known chronic condition. Although take up was relatively low, 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 health care assistant had been trained to give advice on smoking cessation and did not run a specific clinic, but gave advice opportunistically when called upon to do so by the GPs.

Screening for breast, bowel and cervical cancer was offered in line with national standards. The practice performance for cervical smear uptake was 81% for 2013 - 2014 which was similar to other practices in the local CCG area.

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 child immunisations at age 12 months was approximately 95% which was higher than the CCG area of 85%.

A wide range of information was displayed in the waiting area of both surgeries and on the practice website to raise awareness of health issues including information on cancer, meningitis in children, flu and measles.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and a survey of 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 both these sources showed patients were satisfied with their experience at the practice. For example, 86% of patients who responded described their overall experience as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 90% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time as compared to 86% and 83% respectively for the CCG.

We spoke with 9 patients and all said they were treated with respect, dignity and compassion by all the practice staff. Patients said the care was good and staff were friendly, professional and accommodating. Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 42 completed cards and all were positive about the service experienced. Patients felt the practice offered a good service and staff were helpful, caring and took the time to explain everything. They said that all staff treated them with dignity and respect.

We observed staff to be caring and compassionate towards patients attending the practice and when speaking to them on the telephone. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

Staff told us that they had never witnessed any instances of discriminatory behaviour or where patients' privacy and dignity had not been respected. They said there were some patients whose circumstances made them vulnerable such as homeless people or people experiencing poor mental health, who often came to the surgery, but the practice was clear about its zero tolerance for discrimination and made it clear to all patients.

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 good in this area. For example, data from the national GP patient survey from 2014 showed 79% of practice respondents said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results.

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 with all GPs. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. However, it was very rarely used as the GP's spoke the same languages as the majority of their patients.

The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

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. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this feedback. For example, patients described how staff responded compassionately when they had been diagnosed with serious conditions and provided support when required.

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked

Are services caring?

to complete carer's forms where appropriate and there was written information available for carers to ensure they understood the various avenues of support available to them.

There was a robust system of support for bereaved patients both provided by the GP's and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. People were given the option to be referred for bereavement counselling or signposted to a

support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Deaths of patients were discussed at the monthly practice team meetings and staff would attend funerals on occasions.

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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The practice used a risk profiling tool which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The practice is signed up to both the Avoiding Unplanned Admissions (AUA) enhanced service and a 'frail home visiting' enhanced service. The aim of both of these services was to target care to those most at risk of hospital admissions. Both services identify vulnerable, elderly patients and necessitate enabling named clinician-led care, developing a care plan, proactive management and home visiting of elderly patients. The practice kept a register of elderly patients whose care needed to be prioritised at both sites. This register was accessible to reception staff and enables them to be proactive in providing care for these patients. The practice had been allocated a 'Care coordinator' to help to meet the non-medical needs of this group of patients by liaising with external agencies and dealing with issues such as housing and finance. Multi-disciplinary monthly meetings were held to review complex cases. These were attended by community matron, district nurses and the care coordinators. The GP's told us this approach helped to promote holistic patient care.

The practice was signed up to City and Hackney Long term conditions enhanced service for conditions such as diabetes asthma and COPD. This encompassed both prevalence targets and management targets. The GP's said this meant they had to be proactive in identifying patients with long-term conditions and optimising their care. They had a recall system set up where each clinician who led on a certain area was allocated a specific administrator who

recalled patients for annual reviews. Recall lists were printed off weekly and recalls were via phone, letters and texts. All attempts at contact was documented in the patients records. Non-responders were followed up opportunistically. In some cases, repeat medication was changed to 'Acute' with a prescription reminder sent to both patient and pharmacist to encourage review with a GP. The practice held diabetes specialist nurse clinics twice per week, an external diabetes dietician held monthly clinics, and a heart failure specialist nurse visited patients in their homes. In addition, the practice nurses and HCAs regularly undertake reviews for Asthma, COPD, hypertension and diabetes.

We saw evidence that the practice have monthly health visitor meetings where they discuss children in need and complex cases. They maintained a register of vulnerable patients and see walk-in emergencies at both sites and in every clinical session. The GPs demonstrated an understanding of Gillick competency and we saw evidence of them seeing patients under the age of 16 in their clinics. The practice worked closely with the sexual health clinic, the Ivy centre, which was based in the same site as one of their surgeries. The nurse prescriber had additional training in contraception and gives advice to women and is able to give repeat prescriptions for contraception. This removes the need for patients to have a GP appointment

One of the GP's was the lead for vulnerable adults lead and reception staff at both sites have a list of vulnerable patients to ensure they are prioritised for appointments.

Both surgeries are located in areas where a large amount of their patients are socially deprived and have difficulty accessing both medical and social support. The practice therefore offers services to meet their patients 'holistic' needs, such as a weekly benefits advisor attends the practice on Friday mornings and a family action counsellor attends on Thursday mornings. We saw their system diary which confirmed these sessions are well attended.

The practice works closely with link consultants from the local Community Mental Health team (CMHT) who attend the practice quarterly to discuss clinical cases, namely people who have been transferred back to primary care from secondary care. We saw notes from these meetings were typed directly into patient's records. They have an allocated mental health liaison nurse who assesses appropriate patients in the practice and also attends the

Are services responsive to people's needs?

(for example, to feedback?)

CMHT meetings. We saw the practice works very closely with primary care psychology services – IAPT and they refer patients to the Tavistock who provides in-house psychotherapy services when needed.

We saw evidence that both clinical and administrative staff have had Mental Capacity Act training.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises were accessible to patients with disabilities and the toilets were accessible to wheelchair users. The corridors were wide enough to accommodate mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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.

We saw that the practice had recognised the need for equality and diversity training for its staff which was part of their mandatory training. 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 9am to 7pm Mondays – Wednesday, 9am – 2pm on Thursday and 9am – 7pm on Fridays. The practice offers extended hours appointments at both sites: Monday evening (Whiston road), Tuesday evening (Whiston road) and Wednesday evening (Southgate road) where the practice would be open until 7.45pm which was useful to patients with work commitments. The telephones were manned from 8.00am

to 7pm daily and appointments were available from 9pm until 7pm. Appointments were usually for 15 minutes but longer appointments were also available for patients who needed them and those with long-term conditions.

The practice had recently signed up for a new locally enhanced service which will incorporate further extended hours. This required them to offer patients a further 112 appointments per quarter, outside of practice core hours. The partners were in discussion about when to offer these appointments to best suit the needs of our practice and were consulting with the patient participation group PPG on this.

Comprehensive information was available to patients about appointments on the practice website which allowed patients to book appointments and home visits and order repeat prescriptions. Information was displayed in the practice waiting room and on the website directing patients to the NHS 111 and the out of hour's service when the practice was closed. 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 hour's service was also provided to patients in the practice information leaflet.

Patients told us they were satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice. In these circumstances the practice would get patients to complete an 'Immediate treatment request form' on arrival. All patients we spoke with told us they had always been able to get an emergency appointment or talk with a GP on the phone.

Feedback from the national GP survey published in 2014 was positive about the appointment system. 84% of respondents described their experience of making an appointment as good and 86% were satisfied with the surgery's opening hours. Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment stating they could always get an appointment when needed.

Listening and learning from concerns and complaints

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. The practice's complaints policy and procedure 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 a sample of complaints received in the last twelve months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging. However we saw lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

The practice kept a complaints log and also held a quarterly complaints meeting attended by the partners and the practice manager. 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 lead GP told us their vision was to deliver continuity of care and give a good and treatment; however this was not documented. Staff we spoke felt the vision was to deliver high quality care, promote good outcomes for patients and continually strive to make improvements. We found staff were clear about their responsibilities in relation to providing good care at the practice.

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. Staff we spoke with confirmed they had read the key policies such as safeguarding, health and safety and infection control. All seven 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 above national standards. They had scored 918 out of 1000 in 2013 and 888 out of 900 in 2014, which was 4.4% above the CCG average and 5.2% above England average. 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 practice's monthly meetings.

The practice took part in a peer reviewing system with neighbouring GP practices from City and Hackney CCG. We looked at notes and saw that they met quarterly and discussed topics such as collaboration and referral pathways. It was also an opportunity for practices to work together to develop services focused on the needs of the local population for example residential care homes.

Whilst the practice had systems in place to carry out clinical audits, they did not have any completed clinical audit cycles. However, we saw one GP had started an audit on patients with arterial fibrillation (AF) who were taking

warfarin with the aim of monitoring to see whether patients were having regular blood tests to check their INR levels and that appropriate action was taken when where it was too high or too low.

The practice had robust arrangements in place for identifying, recording and managing risks.

Identified risks were included on a risk log maintained by the practice manager with clear actions required and date to be completed by clearly noted. We saw that the risks were regularly discussed at team meetings and updated in a timely way.

Leadership, openness and transparency

Although there were named members of staff in lead roles for example one partner GP was the lead for safeguarding, the practice did not appear to have a clear leadership structure. Some members of staff we spoke with felt it was the senior GP partner, whilst others told us there was collective leadership between the GPs. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that they 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, every month. 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. They felt they worked well together and that they were a highly functional team which listened and learnt, and were aware of their areas of weakness such as having no completed audits which clearly demonstrate improved outcomes for patients. Staff said the leadership team were always open to suggestions.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, the recruitment and qualification checking procedure. We were shown the staff handbook which 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 its patients, the public and staff

The practice had an active patient reference group (PRG) which met quarterly. Information about the PRG was available on the practice website. The PRG included

Are services well-led?

Good 

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

representatives from various population groups including, older people, carers and patients from different ethnic and cultural backgrounds. However, the practice recognised that the group was not representative of the practices patients or example there were no young people, and had tried a number of ways to increase the membership. Meetings were held quarterly and either a GP or the practice manager attended. We were shown minutes of meetings held in 2014 and saw that they had discussed the lowering of the reception counter and the possibility of having an automatic door. We were told minutes were distributed to members and displayed on notice boards in the waiting rooms.

The practice had gathered feedback from patients through PRG patient surveys and complaints received. We looked at the results of the in-house annual patient survey from 2014 and saw that one area reviewed was patient's dissatisfaction with the length of time they have to wait after their appointment time. As a result the practice had created more telephone consultation slots for GPs so that patients who do not necessarily need to come to the practice can speak to their GP. The practice also extended their appointment sessions by half an hour in the morning and half an hour in the afternoon.

Staff told us they could 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 and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. We looked at staff files and saw that annual appraisals were up to date. Appraisals included a personal development plan and staff told us that the practice was very supportive of training. For example the HCA had been trained as a phlebotomist and the whole staff team has received training dementia awareness training.

The practice scheduled meetings for the whole staff team, clinical and non-clinical. We saw from the minutes of meetings that they discussed where improvements to the service could be made.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings to ensure the practice improved outcomes for patients. For example following an incident where a GP was unable to get access for a home visit of a vulnerable patient, the practice had changed its records to ensure 'next of kin' was always documented.