# 70 Norwood Road

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at 70 Norwood Road , also known as Southall Medical Centre, on 8 January 2015. The inspection took place over one day and was undertaken by a Lead inspector, a GP Specialist Advisor and a Practice Manager Specialist Advisor. We looked at care records, spoke with patients, members of the patient participation group (PPG) and staff including the management team.

Overall the practice is rated as 'Good.'

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

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

- Systems including incident reporting protocols, safeguarding measures and infection control procedures were in place to keep patients safe.
- Staff were appropriately qualified to deliver effective care and treatment in line with professional guidelines.
- Patients said that staff were welcoming, caring and treated them with dignity and respect and the GPs involved them in decisions about their treatment and care.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). Most patients were satisfied with access to the service and the appointment system. However, some patients fed back that the practice's opening hours could be improved.

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

Importantly, the provider should:

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- Arrange for the Health Care Assistant to be trained to Level 2 for safeguarding children.
- Ensure availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site.
- Record the vaccine fridge temperatures for the minimum and maximum temperatures in addition to the actual temperature.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Procedures were in place to ensure incidents were reported, analysed and learning shared. Safety alerts received from the NHS central alert system were acted upon however there was no formal arrangement in place for the dissemination and implementation of these. Medicines were managed safely however the practice should record the vaccine fridge temperatures for the minimum and maximum temperatures in addition to the actual temperature. Staff were trained to deal with medical emergencies however, the practice should ensure availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site.

Safeguarding procedures were in place to protect children and vulnerable adults from harm. Staff were knowledgeable on safeguarding both children and vulnerable adults and knew who to report to with any concerns. There was a nominated GP safeguarding lead and there were patient registers for vulnerable adults and children. However, the practice should arrange for the Health Care Assistant to be trained to Level 2 for safeguarding children.

Appropriate pre-employment checks had been carried out on staff before they started working for the practice to ensure they were of suitable character.

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Systems were in place to monitor risk. Where risks had been identified control measures were in place to minimise them. Equipment used by the practice had undergone regular safety checks.

The practice had a carried out a fire risk assessment to identify actions required to maintain fire safety, fire protection equipment was serviced regularly, nominated staff were trained as fire marshals, fire alarm checks and fire drills had been practiced regularly.

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**Are services effective?**

Good

The practice is rated as good for providing effective services. The practice scored positively in their QOF performance and used QOF to steer practice activity

Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation.

The practice had completed clinical audit cycles and we saw evidence of improved outcomes for patients as a result. Staff were suitably qualified to deliver effective care and treatment and the practice worked with other health care professionals to deliver effective care to those patients with more complex needs.

Consent was sought from patients when appropriate and staff had a working knowledge of key legislation such as the Mental Capacity Act 2005.

The practice provided a range of health promotion services and had performed well in areas such as childhood immunisations and cervical screening.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

The results of the national patient survey 2014 showed that 68% of patients described their overall experience of the practice to be 'good' and 52% would recommend the practice to someone new to the area which was below the local CCG average of 70%. However the results of the practices' internal patient satisfaction survey showed that 85% of patients were satisfied with their visit to the practice. We received 23 completed Care Quality Commission patient comment cards and all of these stated that the service was 'good', 'very good' or 'excellent.'

Feedback from patients during the inspection was mostly positive about the services they received. Patients told us that staff were caring and treated them with dignity and respect and this was reflected in the CQC comment cards. We also observed this during the inspection and saw that patient confidentiality was maintained.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

The practice had planned services to meet the needs of the local population. These included diabetes clinics, extended hours for appointments with the health care assistant on Saturdays and

# Summary of findings

longer appointments for patients who needed them. Most patients were satisfied with access to the service and the appointment system. However, some patients fed back that the practice's opening hours could be improved.

The practice had recognised the needs of different groups in the planning of its services. For example, bi-lingual staff were recruited to the practice that were able to speak Punjabi and patients also had access to a telephone interpreting service to help them with their communication needs. The practice premises and facilities were accessible for patients with disabilities.

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) and had a system in place for handling concerns and complaints. Patients' complaints had been acknowledged and resolved in a timely manner.

**Are services well-led?**

Good

The practice is rated as good for being well-led.

Governance arrangements were in place including policies and procedures to govern activity. Policies and procedures were discussed at practice meetings to embed learning with staff.

There was clear leadership and staff were aware of who they were accountable to and their level of responsibility. Regular meetings were held, staff were supported with training and their performance was monitored through annual appraisals. However the practice did not have a formal vision and strategy in place, although staff we spoke to told us that the practice aims included providing an effective service to patients and being a friendly, approachable practice

The practice proactively gained feedback from staff and patients and acted on it to improve services. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Patients over the age of 75 years of age were provided with a named GP and care plans were developed for these patients. Care and treatment was planned with appropriate reviews to meet the identified needs of patients.

There were effective risk assessment processes in place to identify patients at risk of unplanned hospital admission. These patients were reviewed on a regular basis and care plans developed for them.

The practice was responsive to the needs of older people and home visits were provided for patients who were housebound.

The practice worked with other specialists to provide effective care for older patients including end of life care.

**People with long term conditions**

Good

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The practice is rated as good for the care of people with long-term conditions.

The practice provided clinics for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). The practice nurse and health care assistant led clinics for long term conditions and care plans were developed for all patients with long term conditions. All patients with long term conditions were offered annual reviews to check that their health and medication needs were being met in line with best practice. There was a proactive call recall system in place to provide preventative and continuing care for patients. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. All staff were trained in safeguarding children and were aware of the procedures to follow if they were concerned about a child's wellbeing and welfare.

# Summary of findings

Multidisciplinary team meetings were held with GPs, health visitors, social workers and children's centre staff to discuss and monitor vulnerable children under the age of 5 years of age. The practice provided a range of services for families, babies, children and young people including child development checks and baby and child immunisations. The practice website included a 'Pregnancy Planner' which provided patients with comprehensive information on pregnancy, labour, baby care following birth and links to video information on developing birth plans.

The practice used a messaging service which reminded parents when their child's immunisations were due and follow up telephone calls were made if appointments had not been made. Practice appointments were available outside of school hours and the premises were suitable for children and babies.

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

Good

The practice is rated as good for the population group of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and telephone consultations were available on request and Saturday morning appointments were available with the health care assistant. The practice also used a messaging service which sent patients appointment reminders via text message to mobile telephones. The practice offered health checks, travel vaccinations and health promotion advice.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice had a register of patients with learning disabilities and offered annual health checks and longer appointments for them.

An interpreter service was available for patients whose first language was not English.The practice website provided information to explain the role of UK health services, the National Health Service (NHS) and the role of GPs for asylum seekers in 20 various languages. Homeless people were able to register as patients with the practice.

Staff knew how to recognise signs of abuse in vulnerable adults and children and there was a lead GP for safeguarding. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

# Summary of findings

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health.

Call recall systems were in place for mental health reviews and physical health checks for patients. The practice was signed up to the dementia direct enhanced service (DES) to provide an annual health check for people with dementia to improve their health outcomes. Care plans were developed and patients were provided with a named GP.

Staff had received training in dementia care, the mental capacity act and capacity assessments.

The practice worked with other health and social care professionals to ensure a multi-disciplinary approach for care management of people experiencing poor mental health.

# Summary of findings

## What people who use the service say

We spoke with six patients during the course of our inspection including two representatives of the Patient Participation Group (PPG). We reviewed 23 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. These comments were reflected in the results of the practice's most recent patient experience survey and the national patient survey 2014.

All the patients we spoke with were positive about the practice and all of the CQC comment cards stated that the service was 'good', 'very good' or 'excellent.' Patients said all the staff were friendly and treated them in a respectful manner. Patients were generally satisfied with the practice's opening hours and the standard of care they received but would like the practice to implement an online appointment booking service. The national patient survey however showed that 52.6% of patients would recommend their practice which was below the CCG average of 69.5%.

## Areas for improvement

**Action the service SHOULD take to improve**

- Arrange for the Health Care Assistant to be trained to Level 2 for safeguarding children.
- Ensure the availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on site.
- Record the vaccine fridge temperatures for the minimum and maximum temperatures in addition to the actual temperature.

# 70 Norwood Road

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and the team included a GP and Practice Manager Specialist Advisors. The Specialist Advisors were granted the same authority to enter 70 Norwood Road as the CQC inspector.

## Background to 70 Norwood Road

70 Norwood Road provides GP primary medical services through a General Medical Services (GMS) contract (GMS is one of the three contracting routes that have been available to enable the commissioning of primary medical services).to approximately 2,900 patients living in the London Borough of Ealing. Southall Medical Centre provides two GP practices, one at 70 Norwood Road and one at 223 Lady Margaret Road, Southall, Middx UB1 2PT.

Ealing has significant income inequalities with a high proportion of unemployment and 19.2% of children living in poverty. A large proportion of the local population speak English as a second language. Patients registered with the practice are predominantly from an Indian subcontinent background and are Punjabi speaking. The next largest ethnic groups are patients from White and Black backgrounds. The practice serves a young population group with 2.3 % of patients in the over 75 years age range.

The practice team is made up of two female GPs, one male GP, a practice nurse, healthcare assistant, practice manager and four receptionists.

Opening hours are between 8.00am -12:00am and 2:00pm-6.30pm Monday to Friday and Saturday 9.30am to 12:45pm. GP appointments are available between 9:00am -12:00am and 3:00pm-6:00pm during the week. Saturday appointments are available with the Health Care Assistant only. Telephone access is available during core hours and home visits are provided for patients who are housebound or are too ill to visit the practice.

The practice has opted out of providing out of hours (OOH) services to their own patients and refers patients to the '111' service for healthcare advice and onward referral to an out of hours GP service when necessary when the surgery is closed.

The practice is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury.

The practice provides a range of services including child development checks, children's immunisations, adult immunisations, travel advice, maternity care, family planning, cervical smears and healthy lifestyle advice.

## Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

# Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS choices website and the national patient survey 2014. We asked other organisations such as NHS England and Ealing Clinical Commissioning Group (CCG) to share what they knew about the service.

We carried out an announced visit on 8 January 2015. During our visit we spoke with a range of staff including GPs, the practice manager, the health care assistant and reception staff. We spoke with four patients who used the service and two members of the practice's Patient Participation Group. We reviewed comment cards completed by 23 patients sharing 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 patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example a message for a locum doctor to undertake a home visit to a patient in a nursing home was not passed on and the patient did not receive a visit. The practice had taken action to prevent reoccurrence of this incident by developing a new 'Messages for Doctors' form for reception staff to use which was completed each day. Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe.

We reviewed minutes of practice meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last 11 years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events and incidents were reported on a standardised form which included a details of the event, key risk issues, specific action required to prevent reoccurrence and learning outcomes. Staff including receptionists were aware of the process to follow and sent completed incident forms to the practice manager. Staff we spoke to were able to provide examples of recent incidents reported and told us that incidents were discussed at the monthly practice meetings to ensure all staff were kept informed. We reviewed practice meeting minutes and saw that significant events were a standing agenda item for practice meetings.

There were records of significant events that had occurred during the last 11 years and we were able to review these. An example of a significant event related to the collapse of patient in the practice waiting area. As a result of learning from this incident, all staff were trained in the use of the panic button, the emergency trolley was changed from being fixed to mobile, staff were instructed to ensure that all GPs on site should be made aware of the incident and one member of staff should remain with the patient in case the doctor treating the patient requires any assistance.

The practice had a significant event policy which included a process for communicating the outcome and learning to relevant staff. Significant events were discussed as part of the monthly practice meetings and we saw meeting minutes to evidence this taking place. We saw evidence of learning shared within the practice meeting as a result of a significant event which included when printing a prescription with a new additional medication for a patient for the first time, a note was to be added on the blank sheet for the pharmacist's attention notifying the change to the patient's medication.

There was no formal process for disseminating national patient safety alerts to practice staff. Each GP had individual responsibility to access safety alerts that were relevant to the practice and where they needed to take action. However, we saw evidence of a clinical audit which was undertaken in response to a safety alert which related to diabetic patients who were prescribed pioglitazone medication which has been associated with a small increased risk of bladder cancer.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were safeguarding policies in place for both children and vulnerable adults which included contact details for the local safeguarding and social care teams. Flowcharts detailing the procedure for escalating safeguarding concerns were posted in consultation rooms for quick reference to ensure staff reported any concerns promptly.

A training matrix containing staff training records for medical, nursing and administrative staff was made available to us prior to the inspection. We also examined training records during the inspection which included certificates of training completed. The training records showed that all staff had received training in child protection. Administrative staff were trained at Level 1 and GPs and practice nurses were trained at Level 3 in

accordance with national guidance. The health care assistant had been trained at Level 1 however national guidance requires practice nurses and health care assistants to be trained to Level 2.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. The safeguarding lead had been trained in safeguarding adults and also Level 3 child protection to enable them to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

We asked reception staff about their most recent training. Staff we spoke to were able to describe signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Safeguarding contact details including social services and designated child protection doctors were easily accessible and were available via the reception notice board. The practice maintained a register of children who were vulnerable and at risk. Practice staff had also received training in Female Genital Mutation (FGM) in addition to their safeguarding children training. There was an alert message system to highlight vulnerable patients on the practice's electronic records.

The practice had identified that migrants were particularly vulnerable to abuse. In response to this risk, the practice had trained staff in recognising signs of domestic violence and signposting patients to organisations for support. During our inspection we observed flowchart information in the consultation rooms and reception office detailing the procedure and contact telephone numbers following the identification of a patient experiencing domestic violence.

The practice had a chaperone policy and signs were visible in the waiting area and in the consultation rooms offering the chaperone service. The chaperone policy contained guidelines on who could act as a chaperone, the role of the chaperone and confidentiality requirements. The policy strongly recommended that chaperoning should be provided by clinical staff familiar with procedural aspects of personal examination. However, if clinical staff were not available to act as chaperones, two receptionists had undertaken formal chaperone training and we saw evidence of these training certificates. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Clinical and non-clinical staff providing chaperone duties had undergone a criminal records check.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain policy for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a breach of these temperatures. We saw evidence of cold chain procedure training as part of induction training for reception staff in relation to the delivery of vaccines to the practice. The fridge temperature was checked and documented twice a day and we saw records of these checks being undertaken for the last two years and the appropriate temperature range had been maintained. However, the temperature recordings did not include the minimum and maximum temperatures in addition to the actual temperature.

The practice nurse and one of the GPs were responsible for ensuring medicines were in stock and within their expiry dates. Vaccines were recorded with batch numbers, expiry dates, stock balance and were checked regularly with the dates recorded. 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 policy for repeat prescribing which was in line with national guidance and was followed in practice. The policy complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. We saw evidence that prescription training was part of the administration staff induction programme. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. 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.

**Cleanliness and infection control**

Good

# Are services safe?

We observed the premises to be clean and tidy. The practice has a cleaning contract with an external agency and we saw evidence of cleaning task sheets and rotas. Patients we spoke with raised no concerns about the cleanliness of the practice and the comment cards we received also reflected this.

One of the GP partners was the lead for infection control for the practice who had undertaken online infection control training to enable them to provide advice on the practice infection control policy. Staff received induction training about infection control specific to their role and were also provided with online infection control training.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves and coverings were available for staff to use to minimise cross-infection risks.

There was also a protocol for needle stick injuries which included immediate actions to take following an injury and contact details for needle stick injury advice from local hospitals and the occupational health department. The practice had a contract with an external agency for weekly safe removal and disposal of sharps waste.

Clinical specimens were collected from the practice on a daily basis by an external agency. We saw evidence that the Hepatitis B status of clinical staff had been checked and non-clinical staff we spoke with confirmed that they did not come into contact with blood samples and did not handle these directly.

Hand washing facilities were available throughout the practice and posters were displayed above sinks with correct hand washing techniques. Alcohol wipes and hand washing sinks with hand soap were available in the treatment rooms.

An external agency had carried out a legionella (a germ found in the environment which can contaminate water systems in buildings) risk assessment for the practice and the next test due date was July 2015.

**Equipment**

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. The practice had a contract with an external agency to provide PAT testing and calibration of equipment on a routine annual basis. Examples of equipment calibrated included blood pressure monitors, Doppler ultrasound equipment and baby weighing scales. All portable electrical equipment displayed stickers indicating the next testing date which was due in December 2015.

**Staffing and recruitment**

During our inspection we reviewed staff files. The staff files we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, right to work checks, references, qualifications, registration with the appropriate professional body, employment history. We noted that criminal records checks through the Disclosure and Barring Service (DBS) had been undertaken for all clinical staff and also non-clinical staff who provided chaperoning services. Reception staff we spoke with told us that prior to their employment at the practice they were requested to provide evidence of their passport, curriculum vitae, and references which was corroborated with the practice recruitment policy which set out the standards it followed when recruiting clinical and administrative staff.

The practice provided a comprehensive induction for staff as part of the recruitment process. We saw induction programmes for clinical and administrative 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 keep patients safe. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and there was an appropriate skill mix to facilitate the clinics being provided. Staff were required to give a period of one month's notice for annual leave. There was also an arrangement with the main practice for administrative staff to provide assistance and cover where necessary. Locum GPs were rarely booked for clinical sessions as the practice would try to cover staff annual leave and sickness internally.

**Monitoring safety and responding to risk**

Good

# Are services safe?

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 and we saw evidence of health and safety training as part of staff induction. One of the GP partners was the nominated health and safety representative.

We saw evidence of health and safety risk assessments where identified risks were logged in a risk assessment table. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. For example, cleaning up blood spillages was identified as a hazard to staff. The control measures documented to mitigate this risk included the use of hypochlorite granules and we saw evidence that this action had been completed with the provision of biohazard spillage kits available in the consulting rooms.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and received annual refresher training. Emergency equipment was available including access to oxygen and a pulse oximeter (used to check the level of oxygen in a patient's bloodstream).The practice did not have a defibrillator (used to attempt to restart a person's heart in an emergency).

When we asked members of staff, they all knew the location of this equipment and informed us that they had also received recent in-house training regarding the practice's emergency equipment as a result of a significant event involving a patient collapse in the practice.

Emergency medicines were available in a secure room of the practice and all staff knew of their location. Posters informing the location of the emergency equipment were displayed in the reception office. We saw evidence of a log book and record sheets which confirmed that the emergency equipment and medication was checked regularly to ensure the stock was maintained and suitable for use. The emergency medication included those for the treatment of cardiac arrest, asthma attacks and anaphylaxis. Anaphylactic kits containing adrenalin were available in the consulting room and flowchart posters were displayed with the procedure to follow in the event of a patient experiencing anaphylactic shock. 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. Emergencies identified within the plan included loss of access to the building, computer systems, paper medical records, telephone systems, electricity and water supplies and staffing issues. The business continuity plan contained a comprehensive list of contact details for staff to refer to for example electricity and gas suppliers. Staff also informed us that there was an arrangement in place for administrative staff from the main GP practice provider to assist the practice in cases of emergencies.

The practice had a fire safety log book and designated members of staff were nominated as fire marshals. Fortnightly fire alarm checks were undertaken and fire drills had been practiced every six months to ensure patients and staff could be evacuated in the event of a fire. An external agency provided annual fire protection equipment servicing and a fire risk assessment for the practice had been carried out to identify actions required to maintain fire safety.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE guidelines were discussed in the monthly clinical meetings and staff we spoke with gave us an example of a heart failure NICE guideline that had been implemented. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. The GPs used NICE guidance to inform the referrals of patients to secondary care and other community care services appropriately. The practice used a referral management centre to organise patient referrals and the local CCG produced the referral pathways.

The GPs told us they led in specialist areas such as learning disabilities and mental health. The practice nurse and health care assistant led clinics for specific conditions such as asthma, chronic obstructive pulmonary disorder and diabetes which allowed the GPs to focus on patients within their specialist areas. Annual reviews were offered to patients with long-term conditions in line with best practice guidance.

The practice had also recently completed a full review of the disease registers to ensure that the number of patients registered with the practice with certain conditions such as diabetes and coronary heart disease was accurate.

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. Patients we spoke to told us that they felt listened to in decision-making about their care.

**Management, monitoring and improving outcomes for people**

The practice had achieved 95.6% in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. QOF performance was reviewed on a weekly basis by the GPs.

The practice showed us examples of clinical audits that had been undertaken over the last year. These included cancer, inadequate smears, inhaler steroids, minor surgery, infection control and Vitamin B12. 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). The practice undertook a Vitamin B12 audit to ensure that the prescribing was in line with licensed indications, patients were monitored and reviewed regularly and action taken was documented. The audit found that all patients had appropriate documentation in their clinical notes regarding the prescribing of Vitamin B12. 93% of patients had been adequately monitored with their serum B12 level checked within the previous year, however nine patients had not been tested within the previous year.

An alert was put on the electronic system for these patients so that when they attended the practice to collect their next prescription, a blood test form was given to arrange for this test to be carried out and facilitate improved monitoring.

The audit also showed that the vast majority of patients were taking oral supplements of B12 but for 25% of patients, their B12 levels had not risen by this method of intake. To improve this outcome for patients, the practice arranged for patients to receive this treatment via intramuscular means as it was retained in the body for longer periods. The audit cycle was completed with a re-audit which was undertaken which identified an improvement of 1.7% with 94.7% of patients being adequately monitored for their Vitamin B12 treatment.

The practice used a risk stratification tool to identify patients who may be at risk of unplanned admissions to hospital. Patients with risk factors such as chronic obstructive pulmonary disorder (COPD), diabetes, and patients with poor mobility who were living alone, were provided with care plans developed by the practice nurse. These care plans informed patient what to do when they felt unwell to prevent unnecessary attendances to A&E and hospital. At the time of our inspection, 170 patients were

Good

# Are services effective?

## (for example, treatment is effective)

identified as being in the at risk group. This group of patients were also prioritised for same day appointments by the reception team and if appropriate, telephone triaged by the clinicians.

The practice had numerous ways of identifying patients who needed additional support. For example, the practice was participating in an Enhanced Service for patients with learning disabilities which aims to identify patients and offer them health checks as this group are at highest risk of undetected health conditions. The practice had identified patients and kept a register of all patients with learning disabilities and those with poor mental health.

The practice used a template based on the 'Gold Standards Framework' which is a recognised model of care to help doctors, nurses and care assistants provide the high quality care for patients coming to the end of life. The practice had a palliative care register, provided patients with a named GP and liaised with palliative care nurses to discuss the care and support needs of patients and their families.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and infection control. We noted a good skill mix amongst the doctors with leads for safeguarding and learning disabilities.

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 the General Medical Council (GMC) can the GP continue to practice and remain on the performers list with NHS England). All staff completed an induction programme when they started working for the practice.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. We saw appraisal documentation for four members of staff which identified areas for development and timescales for achieving these.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the health care assistant had undertaken wound management training and was currently studying for a Level 2 smoking cessation qualification to be able to provide a smoking cessation service to patients in-house.

**Working with colleagues and other services**

The practice worked with other service providers to meet people's needs and manage complex cases. The GPs attended multidisciplinary group meetings every two months meetings to discuss the needs of complex patients, for example patients experiencing poor mental health. The multidisciplinary group meeting was attended by consultants for the care of the elderly, diabetic consultants, mental health workers, community matrons, social worker, community psychiatric nurse, diabetic nurses and community pharmacists. Staff felt these meetings worked well and were a useful forum for sharing important information.

We were told that the practice held a medicines management meeting every six months which includes working with a pharmacist to discuss patients. For patients requiring end of life care the practice held a palliative care register of patients and worked with palliative care nurses to co-ordinate and manage the care of these patients.

The practice was participating in an Enhanced Service for unplanned admissions to reduce unnecessary emergency patient admissions to secondary care by using a risk stratification tool to identify patients at risk of unplanned admission to hospital and manage their care proactively. In addition to participating in this Enhanced Service, the practice liaised with the local Intermediate Care response team who provide rapid assessment for patients in their home following a referral and develop a multi-disciplinary plan of care for the next three to seven days, supporting the patient at home to avoid admission to hospital or A&E.

For pregnant patients and patients under five years of age, the practice liaised with Health Visitors.

**Information sharing**

Electronic systems were in place for making referrals through 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 reported that this system worked well.

Good

# Are services effective?

## (for example, treatment is effective)

The practice had systems to provide staff with the information they needed. An electronic patient record was used by staff to coordinate, document and manage patients' care. 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.

For information posted to the practice, such as hospital patient discharge letters, these were scanned into the practice's electronic system and assigned to the GPs to be managed.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, one GP we spoke with was able to describe examples of their application of the Mental Capacity Act through their experience providing care for elderly patients living at a local care home with nursing.

GPs demonstrated an understanding of both Gillick and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge).

Patients with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The practice was participating in the dementia Directed Enhanced Service (DES) to identify patients with possible dementia who can then be referred for confirmation of diagnosis. The practice held a staff meeting with all staff to provide training in how to recognise this condition in patients.

**Health promotion and prevention**

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. The practice also offered health checks for patients aged 40 -75. We noted a culture amongst the staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation and alcohol consumption advice.

The practice informed us that the use of illicit drugs such as 'Khat' occurred within the local community population. Khat is a leafy green plant which is a stimulant with similar effects to amphetamine and may cause disrupted sleep and make pre-existing mental health problems worse. In response to this issue, the practice opportunistically utilised mental health annual reviews to refer patients that may require it to the local Drug and Alcohol Team services to help patients stop the use of khat.

The practice performance for cervical screening uptake was 81.3% which above the local CCG target of 80%. At the time of our inspection the practice had administered flu vaccinations to 55% of the eligible patient population registered with the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was performing well for childhood immunisations in comparison to the local CCG average with 90% achievement of target for 2 year old children and 89% for 5 year olds.

The practice nurse was supported by the health care assistant who provided services including phlebotomy, blood pressure monitoring, dementia tests, wound dressings, smoking cessation referrals and healthy lifestyle advice.

Health information was displayed in the patient waiting room including tuberculosis, Ebola, breast screening, health lifestyle advice, vaccination programs and other general health advice. The practice website provided health information for patients including family health, long term conditions and minor illnesses so patients could make informed decisions about their health. Videos were also provided on the website for patients and signposting to organisations such as Diabetes UK.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and the last patient satisfaction survey carried out by the practice. We spoke to six patients during our inspection and we received 23 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed a mixed response in the level of satisfaction of patients with their GP practice. The results of the practice patient satisfaction survey showed that of the 167 responses received, 85 % of patients were satisfied with their visit to the practice. We received 23 comment cards and all of these stated that the service was 'good', 'very good' or 'excellent.' The national patient survey however showed that of the 77 responses received, 68 % of patients described their overall experience of the practice to be 'good' and 52 % would recommend the practice to someone new to the area which was below the local CCG average of 70 %. Actions taken by the practice to improve patient's overall experience, included the recruitment of an additional receptionist, a change in their afternoon opening times from 3pm to 2pm to improve patient access. They had also instructed the reception team to educate patients that an appointment was for one patient at a time as some patients attended with family members who also wanted a GP consultation at the same time.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a glass partition which helped keep patient information private. Staff gave us examples of how they ensure patient privacy was maintained which included avoiding discussions with patients about the reason for their appointment at the reception desk, asking patients to confirm their name and date of birth over the telephone rather than staff repeating them and offering patients to write down their requests if they wished. The practice had a meeting room upstairs from the reception area which staff said could be utilised if a patient wished to have a private discussion with a member of the reception team and this would prevent patients overhearing potentially private conversations.

We received 23 completed cards and all of these were positive about the service experienced. Patients said they felt the practice offered a good service and both clinical and reception staff were helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection and they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. One patient we spoke with felt that the GP showed dignity towards his elderly mother by always engaging and speaking directly to her in consultations as opposed to him who accompanies his mother for her appointments as her carer.

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

The results of the national patient survey 2014 showed that 86% of patients reported that the last GP they saw or spoke to was good at listening to them which was above the CCG average of 84%. 73% of patients felt that the last GP they saw or spoke to was good at involving them in decisions about their care.

During our inspection patients said the GPs involved them in decisions about their care and treatments and this was also reflected in the CQC comment cards we received. One patient we spoke with was pleased with the care she had received and described how she had been involved in decisions about the treatment of her depression and was provided by the GP with alternatives to anti-depressant medication. We looked at some care plans that had been developed for patients over 75 years of age and found these to be well structured including past medical history and medication. The practice informed us that patients were given a copy of their care plans to take home.

Good

# Are services caring?

A telephone interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

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

The patients we spoke to on the day of our inspection were positive about the emotional support provided by staff at the practice and this was reflected in the CQC comment cards we received. Staff told us that if families had suffered a bereavement, they signposted patients if they wished to a bereavement counselling line. Staff had access to details of bereavement services on the computer shared drive. The practice also referred patients to the Improving Access To Psychological Therapies (IAPT) service for treatment of depression or anxiety disorders and the practice website provided patients with an online depression assessment questionnaire to help patients experiencing symptoms to seek further care and support.

The practice had a carers identification protocol to identify carers registered with the practice and ensure that they were referred appropriately to the local authority for a Carers Assessment. The practice website also had an online form for carers to complete so that they could be added to practice list and the practice would endeavour to be flexible with appointment times to accommodate their commitments.

We also saw posters in the patient waiting room which informed patients how to access a number of support groups and organisations such as Carers Direct which offers care and support services to adults looking for some assistance to maintain their independence whilst remaining in their own home.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and were happy with the service provided.

The practice used a risk profiling software which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The GPs attended multi-disciplinary group meetings every two months with external professionals to discuss the care of patients including those at risk of unplanned admissions and A&E attendances.

We spoke with staff about vulnerable patient groups and what measures the practice had taken to engage with these groups and ensure that services were accessible. The practice was participating in a learning disability directed enhanced service which was designed to identify patients aged 18 and over with the most complex needs and offer them an annual health check to improve their health outcomes through the introduction of a health action plan.

There was a high prevalence of diabetes in the local population. To meet the needs of patients with diabetes, the practice ran diabetes clinics and we saw posters in the waiting area signposting patients to 'Neighbourly Care Southall,' a charity run local community centre which was running a campaign inviting the local population to attend the centre to raise awareness of the risk of diabetes. The practice website also provided patients with comprehensive information about diabetes which included uploads of videos produced by Diabetes UK and links to Healthtalk Online which is a charity that provides a forum for people to share their experiences of health and illness.

The practice serves a young population group. To meet the needs of the working age and student population, the practice provided text message appointment reminders but did not offer extended hours for appointments during the week in the evenings. The practice was open on a Saturday morning for patients to access health care assistant appointments however no GP or nurse appointments were available. The practice did however offer GP telephone consultations after the practice had closed during the week and on Saturday mornings where necessary.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG's work had contributed to the improvement of services and they told us it had improved communication between patients and the practice. For example, the PPG suggested that the practice should change the entrance door to an automatic push button entry door for easier access for patients. In response to this suggestion, the practice entrance was changed.

**Tackling inequality and promoting equality**

Staff told us that the majority of patients registered at the practice were from an Indian subcontinent background and were Punjabi speaking. There were a number of languages spoken by various members of staff including English, Punjabi, Italian, German, Arabic, Somali, Swahili and Bravanese. The practice could cater for other different languages through the use of a telephone translation service. The practice website also provided fact sheets which gave information to explain the role of UK health services, the National Health Service (NHS) and the role of GPs to newly-arrived individuals seeking asylum which were available in 20 various languages. The content and style of these fact sheets had been tested with user groups to ensure that the information was clear. The practice did not have however, an induction loop system available to assist patients with reduced ranges of hearing.

The practice had an equality and diversity policy in place and provided staff training through e-learning and we saw evidence of training certificates. Staff we spoke with confirmed that they had completed equality and diversity training in the last 12 months and were able to describe various forms of discrimination. We saw evidence of equality and diversity being discussed in practice meeting minutes where staff were reminded of the importance respecting each person individually irrespective of their colour, race or ethnicity.

The practice had not experienced any homeless persons wanting to register as a patient but the practice manager told us that they would accept homeless patients and would use the practice address in order to register them.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The premises and services had been adapted to meet the needs of people with disabilities including an automatic door button at the entrance and consultation rooms on the ground floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and there was a pushchair parking area. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

**Access to the service**

The practice opening hours were between 8.00am-12:00am and 2:00pm-6.30pm Monday to Friday and Saturday 9.30am-12:45pm. GP appointments were available between 9:00am -12:00am and 3:00pm-6:00pm during the week. Saturday appointments were available with the health care assistant only. Telephone access was available during core hours and home visits were provided for patients who were housebound or too ill to visit the practice. Patients could book appointments by telephone and in person. Appointments were generally ten minutes in length however longer appointments were also available for people who needed them and those with long-term conditions. For example, patients with learning disabilities were offered double appointments and integrated care programme patients were prioritised for appointments.

Telephone access was available during core hours and patients were triaged for appointments. For urgent appointments patients were triaged and seen on the same day. The appointment system had availability for urgent appointments each day. Patients we spoke with and comment cards we received, confirmed that they could see a doctor on the same day if they needed to. For non-urgent appointments patients would be provided with an appointment within two weeks.

Patients we spoke with during our inspection told us that they were satisfied with the opening hours of the practice. The results of the national patient survey which was completed by 77 patients, found that 60% were satisfied with the opening hours which was below the local CCG average of 72 %. However, the results of the in-house practice survey which was completed by 167 patients, found that 72% were satisfied with the opening hours.

To cater for the needs of the working age and student patient population the practice used a messaging service which sent patients appointment reminders via text message to mobile telephones. Repeat prescriptions could be requested over the telephone and were available for collection within 48 hours. During our inspection patients we spoke with and members of the PPG told us that they would like the practice to implement online appointment booking and an online repeat prescriptions service.

Information was available to patients about appointments on the practice website and there was also information for patients on how to access urgent medical assistance when the practice was closed. If patients telephoned the practice when it was closed, an answerphone message gave information on the out-of-hours '111' service.

The practice monitored the appointment system and needs of the patients by undertaking regular 'Did Not Attend' (DNA) appointment audits.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who managed all non-clinical complaints and the and the on call duty doctor managed the clinical complaints in the practice.

We saw that the complaints procedure was displayed on posters in the reception area and there was a complaints leaflet to help patients understand the complaints system. The practice had a complaints policy and maintained a complaints log.

We looked at the complaints log for the last 12 months which recorded complaints received verbally and in writing. We reviewed four complaints and found that these had been managed in an appropriate and timely manner. In response to complaints regarding reception staff, the practice arranged in-house training for staff with the practice manager on message taking and escalation to the on-call doctor. At the time of our inspection the practice had no outstanding complaints being dealt with and no serious clinical complaints had been received in the last 12 months.

The practice reviewed complaints annually to detect themes or trends. We looked at the complaint summary report for the last year and themes identified included recording of messages, communication skills and the

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

processing of prescription requests. Lessons learned and actions taken in response to the complaints received were documented and we saw practice meeting minutes to evidence complaints being discussed and shared with 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 did not have a formal vision and strategy in place. Staff we spoke to told us that the practice aims included providing an effective service to patients and being a friendly, approachable practice

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive of any computer within the practice. The practice had a proactive approach to embedding policy into the day to day practice operations. Each month a staff member was nominated to choose a policy and provide a presentation based on this policy for their colleagues at the practice meeting. Although policies were regularly discussed at team meetings, we reviewed six policies and procedures documents and three did not have formal review dates to indicate that they were up to date. The practice's policies and procedures were, however, updated on an ad hoc basis to take account of new developments and changes.

We spoke with four members of staff and they were all clear about their own roles and responsibilities. However there was no formal leadership structure document developed indicating these roles and some staff we spoke to were unable to identify named members of staff in lead roles such as infection control. Staff told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The overall QOF score for this practice for 2013/14 showed it had performed 1.7 % above the CCG average and 1.8 % above the England average. QOF data was regularly discussed each week to monitor progress with targets.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. We saw evidence of a risk log which addressed a wide range of potential issues, such as cleaning up blood spillages and the handling, carrying or decanting of hazardous liquids. Where risks were identified risk assessments had been carried out and risk control measures produced to mitigate the risk.

**Leadership, openness and transparency**

The practice had a programme for meetings. Whole practice team meetings were held monthly, QOF meetings were held weekly, clinical meetings were held monthly and multidisciplinary meetings were attended by clinical staff every two months. All practice meetings were minuted and stored on the computer shared drive.

We spoke with three 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. 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 reviewed a number of policies and procedures, for example recruitment and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice also had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff were aware of the whistleblowing policy if they wished to raise any concerns and were able to describe circumstances in which they would use it.

The practice manager was responsible for human resource policies and procedures. Policies such as absence and sickness and work performance and capability were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

**Seeking and acting on feedback from patients, public and staff**

The practice had gathered feedback from patients through patient surveys, the Friends and Family Test (a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) suggestions, and complaints received. The practice had an online comments and suggestions form on the practice

# Are services well-led?

Good

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

website which asked patients for their feedback on comments about the practice and suggestions as to how they could improve the service. We looked at the results of the national patient survey and 82% of patients said that the last appointment they had was convenient however only 34% found it easy to get through to the practice by phone which was below the local CCG average of 70%. As a result of this feedback, the practice added more telephone lines and had arranged the staff rota to ensure that there were always two members of the reception team on shift to cope with busy periods. The practice were also planning to install an online appointment booking service in response to feedback from patients to improve access to appointments.

Staff and members of the PPG we spoke to provided examples of other improvements that had been made to the practice as a result of patient feedback which included an automatic push button at the entrance door and new chairs in the waiting area.The PPG had also requested the provision of a TV monitor within the waiting area to advertise information about the practice and health promotion advice which the practice had agreed to implement within a year.

During our inspection we observed patients in the waiting area completing the Friends and Family test and also saw the provision of a suggestion box in the practice entrance.

We saw evidence of practice meeting minutes where patient complaints were discussed and staff we spoke to were able to provide an example of learning that had resulted from a patient complaint.

The practice had an active patient participation group (PPG) of approximately 12-15 members. During our inspection we met with two PPG members who informed us that the PPG was representative of both the ethnic population and age groups served by the practice including working age, older people and Indian, White and Black patients.

The PPG met every quarter and was attended by a GP and some practice staff. The practice commissioned an internal patient survey 2013 which was developed in order to improve patient care. Two of the PPG members we met during our inspection told us that the PPG worked with the practice in the development of the questions for the patient survey. The results and actions agreed from this survey were discussed with the PPG and were available on the practice website. We saw an action plan that was developed as a result of the patient survey and we saw evidence of some actions that had been carried out and timescales for the completion of the remaining actions. In between meetings one PPG member told us that some members came into the practice once a month to talk to patients and record their feedback. This feedback was then passed on to the GPs and discussed at the next meeting.

The practice had gathered feedback from staff through practice meetings and appraisals. Staff told us their managers were approachable and they felt comfortable to give feedback and discuss any concerns or issues. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff appraisals and saw that regular appraisals took place which identified areas for development with timescales for achieving these. Staff we spoke to told us that their appraisals were effective in monitoring their development.

Staff told us that the practice was very supportive of training and development. Reception staff told us the practice manager informed the team of training courses available and the health care assistant told us that he was currently being supported to train to level two for smoking cessation so that the practice could offer a smoking cessation service to patients in-house.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients. For example, an incident occurred where a patient came into the surgery to collect their repeat prescription on numerous occasions but was told by staff that it was not ready. When the prescription was finally found, it had been filed in the wrong section of the alphabet. Staff were reminded to be careful when receiving prescriptions from patients, when issuing them and also when filing them away to prevent a reoccurrence. The incident was discussed during at a practice meeting to ensure learning was shared.