# Dr Sunita Bhalchandra Kulkarni

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Are services safe? | 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 inspected Dr. Sunita Bhalchandra Kulkarni practice (also known as Stoke Health Centre) on 17 November 2014. We inspected this surgery as part of our new focused, comprehensive, inspection programme. This practice had not been inspected before. We looked at how well the practice provided services for specific groups of patients. These included; older patients, patients with long-term conditions, families, children and young people, working age patients (including those recently retired and students), patients living in vulnerable circumstances and patients experiencing poor mental health (including people with dementia). The overall rating for this practice was good.

**Our key findings were as follows:**

- There was a clear management structure to support and guide staff to deliver safe, responsive and effective care to patients.
- There were good governance and risk management measures in place.
- The practice had a clear vision and strategy in place.
- The practice had employed a pharmacist in July 2014 to complete long term conditions medication reviews, helping patients to make the most of medicines and to reduce unplanned admissions to hospital.
- The practice took time to listen to the views of their patients and ran an active Patient Participation Group and any actions identified were implemented and used to improve the service.
- Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

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

**The provider should:**

- Ensure staff attain the appropriate level of training in safeguarding adults and children according to their role.
- Ensure senior staff are aware of the arrangements in place within their Business Continuity Plan.

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- Carry out improvement measures to ensure the suitability of the GP examination room for patients and to enable wheelchair accessibility, in the event that the nurses' consultation room was fully booked.
- Reduce the probability of accidental interruption of electricity supply to the vaccine fridge, such as installing a switchless socket or clearly labelling the vaccine refrigerator plug with a cautionary notice such as, do not unplug or switch off.

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 overall for providing safe services.

Staff understood their responsibilities to raise concerns and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from National Institute for Health Care Excellence (NICE) and used it routinely to enable best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received the majority of the training appropriate to their roles and any further training needs had been identified and planned. The practice had conducted staff appraisals and personal development plans for staff. Staff worked with multidisciplinary teams. The practice engaged with the Clinical Commissioning Group (CCG) and with local initiatives and strategies to improve the health and well-being of their patients.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and the majority felt they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. All 25 CQC comment cards received and the patients we spoke with commented positively on the practice, the kindness of the staff and the treatment received. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. To ensure privacy for patients and enable wheelchair accessibility the GP examination room needed to be improved.

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

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure

# Summary of findings

improvements to services where these were identified. Patients said they found it easy to make an appointment with their GP and that there was continuity of care. Urgent appointments were available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Evidence showed that the practice responded quickly to issues raised. Learning from complaints took place and was shared appropriately with staff and other stakeholders.

**Are services well-led?**

Good

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

The practice had a clear vision and strategy. Staff were clear about the practice vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active. Staff had received inductions, and had attended staff meetings and events. The practice was co-located with another practice and all staff, other than the GP worked for both practices; they held regular joint meetings and learning was shared from each practice.

# 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 patients.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice was knowledgeable about the number of older patients using the service and their health needs. They maintained a register of patients' health conditions and whether patients were unable to attend the practice due to their frailty. They used this information to provide services in the most appropriate and timely way. There were no patients registered at the practice who lived in a nursing home.

The practice offered some enhanced services, for example diabetes management and flu vaccinations. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. We saw the practice monitored the uptake of the flu vaccinations in patients over 65 years old and saw that 70, 78 or 79 year olds registered at the practice were offered the shingles vaccine to assist with their health and well-being. The shingles vaccination uptake rate at the practice was 83%.

### People with long term conditions

Good

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

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. We saw that 58.7% of patients registered at the practice had a long-standing health condition and 42.5% with health-related problems in daily life. Longer appointments and home visits were available when needed. Polypharmacy medicine reviews (patients on multiple medications) were done annually in general around the patients' birth dates. They were completed more regularly for patients on disease-modifying anti-rheumatic drugs (DMARDs) and patients on anti-coagulation (blood thinning) medicines.

Patients were seen by either the GP for a structured annual review or the nursing staff to check that their health and medication needs were being met. The practice engaged with the Community Matron and multidisciplinary teams regularly regarding their patients with complex needs or long term conditions who were unable to attend the practice. They worked in partnership to improve patient outcomes.

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**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young patients.

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 accident and emergency (A&E) attendances. Immunisation rates were good for all standard childhood immunisations. Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. We saw the practice monitored their cervical screening for young people from 25 years old, as well as pregnant mothers' uptake of the flu vaccination. Chlamydia screening was generally organised at the local schools and colleges but was also available at the practice.

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

Good

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

The percentage of patients registered at the practice of working status or in full-time education was 69.2%. The practice had recently adjusted the services it offered to ensure the needs of working age patients, patients recently retired and students could be met and had increased access two evenings per week. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability.

We saw that 0.58% of patients registered at the practice had a learning disability and of those, 66% had received an annual health check to date. The practice informed us they were able to offer longer appointments for patients with a learning disability.

We saw that patients with alcohol related conditions were seen in the practice and could also be referred to a local service which helps to support patients and families overcome the harm caused by alcohol, drugs and gambling.

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

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

Good

The practice is rated as good for the care of people experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

We saw that 0.35% of registered patients at the practice had a dementia diagnosis and that of those, 94.4% had a care plan in place according to Public Health England figures 2012/13. The GP showed us their dementia patient unplanned hospital admission data was 40% which was high. The high percentage figure reflected the fact that the practice had very few patients registered as requiring dementia care and had no care home patients.

The practice had held a carers event which included carers of patients with poor mental health. The percentage of patients registered at the practice with caring responsibilities was 18.5%. During the inspection the GP found it problematic to locate the details of carers. Access to this information could be improved.

The practice had literature available for patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

# Summary of findings

## What people who use the service say

We spoke with four patients during the inspection and received 25 Care Quality Commission comment cards. We spoke with male and female patients, working age patients and mothers with children. All of these patients were very complimentary about the care provided by the nursing and reception staff and the positive and friendly atmosphere fostered by all staff. They found the GP, nurses and reception staff to be professional. They found the clinical staff to be knowledgeable about their treatment and care needs. Patients reported that the whole staff team treated them with dignity and respect.

The practice had a patient participation group (PPG) who met regularly. The PPG informed us that the meetings were productive and effective, their views were listened to and where appropriate acted upon in a timely manner. They raised no concerns about the practice and informed us they found them to be responsive to local patients' needs. They said that the staff were professional, approachable, and compassionate and they treated patients as individuals, with dignity and respect.

We looked at the National GP patient survey results for Dr Sunita Bhalchandra Kulkarni published in July 2014. 317 surveys were forwarded to patients at the practice and 104 were returned, which gave a 33% completion rate. The survey results found that 90% of patients who responded to the survey found it easy to get through to the practice by phone, 96% were able to get an appointment to see or speak to someone the last time they tried and 80% describe their overall experience of this practice as good. However there were areas in which improvements were needed as only 67% would recommend this surgery to someone new to the area and only 60% said the GP they saw or spoke to was good at involving them in decisions about their care. The practice was aware of the survey results and had action plans in place to address any shortfalls. The PPG had also completed a satisfaction survey in February 2014. 52 Questionnaires were analysed by the practice and they found on average 88% of patients who responded reported high levels of satisfaction with various aspects of their GP consultation.

## Areas for improvement

**Action the service SHOULD take to improve**

Ensure staff attain the appropriate level of training in safeguarding adults and children according to their role.

Ensure senior staff are aware of the emergency arrangements in place within their Business Continuity Plan.

Carry out improvement measures to ensure the suitability of the GP examination room for patients and to enable wheelchair accessibility, in the event that the nurses' consultation room was fully booked.

Reduce the probability of accidental interruption of electricity supply to the vaccine fridge, such as installing a switchless socket or clearly labelling the vaccine refrigerator plug with a cautionary notice such as, do not unplug or switch off.

# Dr Sunita Bhalchandra Kulkarni

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

## Background to Dr Sunita Bhalchandra Kulkarni

Dr. Sunita Bhalchandra Kulkarni provides a weekday service for 1,372 patients in the Stoke-on-Trent area and is part of the NHS Stoke on Trent Clinical Commissioning Group (CCG). Stoke on Trent is the 16th most deprived area out of 326 local authorities in England. Public Health England figures show that 58.7% of patients registered at the practice have a long standing health condition and the largest percentage of the surgery population, 69.2% are either in paid work or in full-time education.

The practice opens Monday and Friday from 8am to 6.30pm and Tuesday and Wednesday from 8am to 7pm, it closes at 2pm on Thursdays. When the practice is closed and during the out of hours (OOH) periods patients are requested to contact either the 111 service to see a GP or the ambulance service for emergencies.

The practice GP is supported by two part time practice nurses and a healthcare assistant. The staff team includes a practice manager as well as reception and secretarial staff. The practice use the same locum GPs, when required, for continuity of service and support for their patients. The GP has their professional details available for patients to read on the surgery website.

The practice life expectancy figures for male and female patients were found to be lower than the CGG and England's national average. We saw that Stoke on Trent was the 16th most deprived area out of 326 local authorities in England.

Clinics run by the practice include amongst others; childhood immunisations and long term condition management which includes a wide range of conditions, for example; diabetes, heart disease and hypertension (high blood pressure), and travel clinics.

## Why we carried out this inspection

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

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# Detailed findings

## How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

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

• People living in vulnerable circumstances

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

Before carrying out our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 November 2014. During our inspection we spoke with a range of staff and spoke with four patients who used the service. We reviewed 25 CQC comment cards where patients shared their views and experiences of the service.

We looked at how staff managed patient information received from the out of hours team and patients phoning the service. We saw the ordering of repeat prescriptions, how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

Good

# Are services safe?

## Our findings

### Safe track record

Information from NHS England and NHS Stoke-On-Trent Clinical Commissioning Group (CCG) indicated the practice had a good track record for maintaining patient safety. We reviewed policy records and found that policies were regularly reviewed as per best practice or amended as soon as a change in either policy or legislation occurred. We saw that all staff had been trained to at least a minimum level of basic life support.

We reviewed a random selection of safety records, incident reports and minutes of meetings 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 the longer term.

There were multiple information sources in place to ensure a shared awareness of key risks with all staff. For example, the practice had systems to promptly manage national patient safety alerts in order to protect patients.

We saw that that any complaints once investigated were analysed, summarised and reviewed to identify trends or recurrent risks.

### Learning and improvement from safety incidents

In the period between December 2013 and September 2014 there had been three reported significant events. We found there were no identified themes or patterns to these events. These included clinical and non-clinical issues. We saw that each incident had been analysed to consider what had occurred and why, and what lessons had been learnt. Where appropriate, measures had been put in place to prevent future recurrence or to improve care. We saw that lessons learnt were shared when appropriate to do so with the practice team and the CCG.

We found that staff actively reported any incidents and viewed this process as a positive way to ensure they provided a high standard of patient care. We found that any changes to national guidelines, practitioner's guidance and any medicines alerts were discussed at staff meetings and staff received email updates. Staff met on a regular basis and those who attended the formal meetings confirmed the value and effectiveness of the meetings. The staff found that this information sharing meant they were confident that the treatment approaches adopted followed best practice. The majority of these meetings were minuted. Minutes which outlined the content of the meetings improve governance mechanisms and minimise the potential of staff misinformation or error. The GP informed us that relevant information from meetings such as palliative care were updated within the patient record.

### Reliable safety systems and processes including safeguarding

We saw evidence that health and safety was managed effectively within the practice. We saw that staff were aware of health and safety issues. For example: needle-stick injury protocols, instruction on the location of equipment for use in emergencies and emergency fire procedures.

We saw evidence that the practice had systems in place to ensure fire alarms and equipment were regularly tested and maintained. Emergency exit routes were clearly signposted. We saw that all staff had completed training on fire safety as part of their induction with further annual reviews. Alerts could also be raised using the practice computer system should a member of staff require emergency assistance.

There were procedures in place for managing and dealing with safeguarding children and adults. Staff demonstrated they could access the local authority's safeguarding policy and procedures. The GP took the lead role in safeguarding adults and children. The practice manager forwarded information to show the GP had been booked to attend updates in respect of Level three training. The nurses had received Level one training in safeguarding in 2012. The training expectation is Level two for nurses. The practice manager confirmed and we saw evidence that further, appropriate level training in vulnerable adults and children's safeguarding was booked following the inspection.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and told us how information would be recorded on patient notes if a safeguarding concern was raised. 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 both working hours and out of normal hours. Contact details were easily accessible. The practice manager informed us that the GP would attend any local authority safeguarding board and local multi-disciplinary meetings where able to do so. Otherwise they would forward appropriate documentation to inform the meetings.

Good

# Are services safe?

Staff understood what was meant by the term whistleblowing and the practice had a policy in place.

This meant there were processes in place to assist staff to expose poor care or practice by others such as colleagues, if any became apparent.

A chaperone service was available for patients provided by appropriately trained nurses and the healthcare assistant.

**Medicines management**

A practice protocol for medicine reviews and repeat prescribing was in place and had been reviewed in 2014. The practice regularly checked that patients receiving repeat prescriptions had at least an annual medicine review with the GP. In general, apart from exceptional circumstances, patients who were due a review were invited to attend the practice prior to the next prescription being issued. We saw that 69% of patients whose total number of items prescribed was greater than six had received an annual medicine review and that 100% patients on the practices Mental Health register had received their medicine review.

The practice contracted a pharmacist to complete medicine reviews for patients with long term conditions. These took place every other Monday afternoon in patients' homes to assist in the prevention of unplanned hospital admissions under the local improvement scheme. The pharmacist discussed with the patient their medicines, for example their ability to use their respiratory inhaler effectively, or any medicine side effects. They assisted patients to understand the therapeutic use and impact of their prescribed medication. This was to improve their health and well-being, which in turn might reduce the risks to the patients of an unplanned admission to hospital. Following these home visits the pharmacist produced a report and discussed their findings and any plan of action required on a one to one basis with the GP. Progress on the action plan and its implementation was then tracked by the pharmacist and GP.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy to ensure that medicines were kept at the required temperatures. The policy described the action to take in the event of a fault developing with the refrigerators. There were clear cold chain protocols in place. The cold chain is the system of transporting and storing vaccines within the safe temperature range of 2°C- 8°C. The practice staff followed the policy. The practice needed to reduce the probability of accidental interruption of electricity supply to the vaccine fridge, such as installing a switchless socket or clearly labelling the vaccine refrigerator plug with a cautionary notice such as, do not unplug or switch off.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance and we saw evidence that the nurses had received appropriate training to administer vaccines. The medicines fridge temperatures were appropriately recorded and monitored and vaccine stocks were well managed.

Oxygen was stored appropriately and ready for use.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw that a review of all patients issued antipsychotic drugs between April and November 2014 had been completed and that 63% of these patients were on repeat prescriptions and had received regular reviews.

We saw that the practice had copies of appropriate briefings regarding medicines, for example the Optimising Safe and Appropriate Medicines Use (briefing) June 2013 (v3).

Security measures were in place for prescriptions access. When making home visits the GP took suitable precautions to prevent the loss or theft of forms, such as ensuring prescription pads were carried in a locked carrying case and not left on view in a vehicle.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example Disease-Modifying Anti-rheumatic Drugs (DMARDs) are a group of medicines that are used to ease the symptoms of rheumatoid arthritis (RA) and reduce the damaging effect of the disease on the joints. The GP reviewed the patient records on DMARDs and patients who were on specific anti-coagulation medication

requiring regular blood tests every month. This was to check they were in line with good practice and had received regular reviews. Staff demonstrated that based on patients' blood test results, appropriate follow up action was taken.

### Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken update training in 2014 to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received regular updates in line with the local CCG mandatory training requirements. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures for the prevention and control of infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Notices about hand hygiene techniques were appropriately displayed and hand washing sinks with hand soap, hand gel and hand towel dispensers were available in examination and treatment rooms.

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer and pulse oximeters. We saw that one item had failed on calibration and we asked what had happened with the item as it was unclear. The practice manager spoke with the company. The company informed us what had happened. Following the inspection the practice manager confirmed that the item had been disposed of. The practice had adult pulse oximeter probes (this is a simple non-invasive technique and provides a percentage check on a patients oxygen levels) but had no child probe available. During the inspection the practice manager requested details from a manufacturer regarding the details and purchase of a child oxygen saturation probe.

### Staffing and recruitment

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

The practice manager and GP informed us that locum GPs were rarely used other than for annual leave and sickness which was verified in the records we reviewed. The practice maintained continuity of care for its patients by the use of the same locum GPs who knew the practice and its day-to-day routines. We saw that the practice manager had conducted checks prior the GP locum attending the practice, such as checks on the General Medical Council NHS Performers list to ensure their registration was valid. It was determined that the GP took the lead role in determining the use of a locum GP. The locum GPs experience, skills, expertise and knowledge were known to them. The practice needed to ensure records were maintained in respect of locum GP recruitment and indemnity checks. They assured us this would be addressed in future.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Good

# Are services safe?

Staff told us there were sufficient staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw records that demonstrated that actual staffing levels and skill mix were in line with planned staffing requirements.

### 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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that any risks identified were discussed at clinical meetings and within team meetings. For example, the practice manager had shared the recent findings of their inadequate smear audit and compared the practice rate to the national average. The audit found there were no training issues identified and the results were at a reasonable level. Staff also gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice also monitored repeat prescribing for patients on medicines for mental ill-health.

There was little staff turnover at the practice. We saw evidence the practice tried to plan ahead for succession if a vacancy was anticipated to minimise any impact upon the service. For example, the early recruitment of a replacement member of reception staff to allow for seamless handover of the role.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a patient's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. We saw that the defibrillator battery had been recently changed and the electrodes were well within the date of expiry.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia (low blood sugar). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We saw that the practice had the 2010 Resuscitation Guidelines in place which were the most current. The staff had awareness of the Resuscitation Council (UK) Equipment and drug lists guidance for cardiopulmonary resuscitation in Primary Care published November 2013. Staff received regular basic life support training and training associated with the treatment of anaphylaxis (shock).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed and staff would use the allocated mobile phones in the event of a telephony failure. Staff knew what to do in event of an emergency evacuation. Staff were aware which staff member was the fire marshal on the day of the inspection and who was responsible for health and safety. The practice manager was aware of the location of the business continuity plan and its content however we found that not all senior staff had this awareness. The practice manager assured us this would be discussed at their team meeting.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

We saw that the practice followed national strategies relating to caring and treating patients. The practice kept up to date disease registers for patients with long term conditions, such as asthma and chronic heart disease and strived to complete annual health reviews in a timely manner.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

Clinical staff also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication, for example for mental health conditions. We saw that to date 66% of adult patients with learning disabilities had attended for review. The GP demonstrated that care plans were in place but these could have been more explicit. We discussed what happened when patients with learning disabilities did not attend for review. The staff told us that letters were forwarded to remind patients of the appointment and reminder phone calls would be made. We were told that where the patient did not attend the GP made contact with them to ensure the patient's well-being.

We saw that several patients with severe mental health concerns had received annual reviews. Eighteen months ago the practice had initiated a carer event, with a patient and their carer who consented to presenting and discussing their experiences. The Patient Participation Group (PPG) told us that attendees found this useful and informative.

We found that individual patients with multiple conditions appeared on several lists which required consolidating. This may provide staff with a more effective tool in the management of data on patients with long term conditions. The practice manager informed us staff had received training in the use of their electronic software but further advanced training was needed in order to maximise its usefulness.

The practice had also completed a review of patients with high blood pressure in May 2013. In 2013 there were 75 patients with high blood pressure with an age range between 20 to 91 years. This review was repeated in February 2014 and the number of patients with specific high blood pressure recordings had reduced to 58 with the measures they had put in place. The GP found following the British Cardiac Society guidelines and the treatment options the GP had selected, the number of patients with specific high blood pressure recordings had reduced. This was also assisted by the nurses promoting regular blood pressure checks, urine and blood tests and ECG monitoring, as well as patient health promotion education.

### Management, monitoring and improving outcomes for people

We saw that a variety of clinical audits had been completed and the findings disseminated to staff. A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. The GP had conducted an audit between April and September 2013 on diabetic patients with HbA1c (glycated haemoglobin or blood glucose levels that were above a specific reading, as part of their Quality Improvement Framework (QIF) with the local Clinical Commissioning Group (CCG). The QIF is refreshed on an annual basis to ensure that targets are relevant, aspirational and are mapped to the national and CCG priorities. For people with diabetes this was important as the higher the blood glucose level, the greater the risk of developing diabetes-related complications. The GP felt that the purpose of the audit was achieved as they reviewed all their diabetic patients and referred patients with high blood glucose levels to the community diabetic clinic for individual steps to be taken. They also found that each individual patient had received a different treatment option in attempts to reduce their blood glucose levels. The GP advised that a repeat audit would be undertaken in the future.

Clinical audits were often linked to medicines management information, safety alerts or as a result of information from

Good

# Are services effective?

## (for example, treatment is effective)

the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice used information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice met the QOF clinical targets and had no reported outliers.

The GP had completed a survey, initially out of clinical interest, on tackling obesity in the practice. They reviewed patients on the obesity register with a Body Mass Index (BMI) over 30 and between the ages of 18 to 39 years. The GP concluded the audit was difficult and GP advice was not always successful and had not resulted in many patients losing weight, for a number of reasons including patient motivation. A small percentage of patients in the practice with BMI over 40 and 45 were referred for surgical intervention. It was clear from the September 2014 clinical practice meeting that patient events, such as healthy walks held by the practice in January 2014 were being planned. The intent was to invite at risk patients, including diabetic, ischaemic heart disease and patients with a BMI greater than 25, to become involved in the scheme. We saw that the practice were aware of the QIF Lifestyle Coach referrals made to assist in providing patients with support in making healthier lifestyle choices as noted in their September 2014 clinical meeting minutes. The outcome of the audit was the continuation of the healthy lifestyle advice and to make appropriate referrals to the Lifestyle Coach initiative where appropriate to do so.

The practice was also aware of the QIF on smoking cessation and obesity and the promotion in practices of NHS Health checks. The Healthcare Assistant at the practice had completed courses of study in smoking cessation, second hand smoke awareness training and completed a Nicotine replacement therapy course to improve outcomes for patients with education and smoking cessation advice.

A three monthly palliative care meeting took place attended by members of the multi-disciplinary team and included for example; the GP, a representative from the district nursing team and Macmillan Nurses. During the meetings they considered what worked well, less well, what would have worked better and, with improvements, what would be different.

### Effective staffing

Practice staffing included the GP, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff attended appropriate the practices mandatory courses such as annual basic life support. Where gaps in training had been identified such as nurse safeguard training to at least level two, the practice manager verified that staff were booked onto the next available training date.

The GP was up to date with their yearly continuing professional development requirements and on going revalidation and appraisals. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council. The GP had appropriate indemnity insurance coverage in place. All staff had annual appraisals to review performance at work and identify learning and development needs for the coming year. The practice manager informed us that staff appraisals (other than for the GP) were completed in January each year. The practice manager demonstrated that should poor performance be identified appropriate action would be taken to manage this.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and long term condition health checks. Staff with extended roles received appropriate specialist training such as asthma and diabetes additional training. The GP and practice manager were very supportive of staffs' personal development and provided staff with extra support to achieve qualifications which would increase the staff member's effectiveness and that of the service provided to their patients.

Although no formalised staff supervision was recorded, other than the annual appraisals and training sessions, staff felt they received appropriate support and used their regular meetings as group support. Staff told us they worked well as a team, all enjoyed working at the practice and felt their strength was that they worked as a team and had good access to support from each other. We found there was a range of staff meetings to support staff, as a form of effective communication, provide learning opportunities and to case review. These included amongst others: clinical meetings, team meetings, patient participation meetings and quarterly multi-disciplinary palliative care meetings.

Good

# Are services effective?

## (for example, treatment is effective)

### Working with colleagues and other services

The practice worked with other health and social care providers to meet patients' needs. They worked with the local district nursing team, midwives, health visitors and for patients requiring palliative care the Macmillan nurses amongst others.

The staff and GP informed us that contact was made with the out of hours (OOH) provider to make sure there was a full exchange of information about any patients receiving palliative care or to inform them of specific information such as vulnerable children or adults safeguarding concerns.

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, x-ray results, and letters from the local hospital including discharge summaries, and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP saw these documents and results and was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held quarterly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. Staff were aware of the importance of appropriate sharing of important information and felt this system worked well for their patients.

### Information sharing

All staff attended information governance, equality and diversity and confidentiality training. We saw that information governance training included amongst others; records management and the NHS Code of Practice, access to health records, secure transfers of personal data and password management.

Access to patient information was dealt with in accordance with NHS guidelines. The practice followed the Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000) and the GP was the Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of a patient and their information and enabling appropriate information-sharing. This supported staff to ensure that only appropriate and secure information sharing took place. Information would not be given to any other bodies without first gaining the patient's consent, unless there were exceptional circumstances as stated in the above mentioned Acts.

Staff were able to clearly explain the processes, checks and safeguards that took place for the safe transit of patient's paper and electronic records.

Information sharing took place appropriately, such as within multi-disciplinary team meetings, patient advanced directives, palliative care meetings and shared care such as hospital referrals and discharges, and community team involvements. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff received training on the use of 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

Nursing staff were aware of how to locate the practice information which dealt with the Mental Capacity Act (MCA) 2005 and best interest decisions. This legislation seeks to ensure decisions made about patients who do not have capacity are made in their best interests.

We found the GP was aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. They understood the key parts of the legislation and were able to describe how they implemented it in their practice.

The practice had a consent policy which included documenting consent for specific interventions. The nurse or GP sought consent and approval for treatments such as vaccinations from the child's legal guardian. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged 16 years old or less who have the legal capacity to consent to medical examination and treatment). These were an integral part of the clinical

Good

# Are services effective?

## (for example, treatment is effective)

staffs' role and would be electronically recorded in the patient's record. We saw from the reception staff meeting minutes in October 2014 that consent and Gillick competencies were discussed with staff and training given.

**Health promotion and prevention**

All new patients were asked to complete a health questionnaire and offered a consultation with the healthcare assistant, nurse or GP. We found that staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice.

The practice had signed up to the CCG Quality Improvement Framework and staff had awareness of the CCG's 'Putting Patients First' five-year strategic plan. We were informed that the QIF was underpinned by a learning and development programme. The Joint Strategic Needs Assessment (JSNA) pulls together information about the health and social care needs of the local area. This information was used to help focus local health promotion activity. For example the percentage of reception schoolchildren measured as obese in Stoke-on-Trent had increased from 10.9% (2006/7) to 12.2% (2011/12). During the same period, the percentage in England fell from 9.9% to 9.5%.

Patients were encouraged by the practice to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

The practice also offered NHS Health Checks to all its patients aged 40-75. At the time of inspection the practice was promoting flu vaccinations. There was a range of health promotion information on display in the waiting area patients used and within the consultation and nurse examination rooms.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

Patients spoke positively of their dealings with both clinical and non-clinical staff. We spoke with four patients and they told us they were treated with dignity and respect. They said that reception staff were excellent and the nurses and GP were kind, thoughtful and caring. The 25 Care Quality Commission comment cards received were complimentary about the care and treatment provided. Patients who completed the comment cards found the doctor and nurses delivered a very friendly and family orientated service.

The practice had a Patient Participation Group (PPG) who conducted a patient survey in February 2014. Questionnaires were randomly handed out to patients attending the practice or collecting prescriptions for a one month period. 52 completed questionnaires were analysed by the practice manager. 100% reported a high level of satisfaction with the reception staff.

We saw staff speaking with patients attending the practice and heard them engaged in conversation with patients on the telephone. They followed the practice confidentiality policy when discussing patients' treatments in order that confidential information was kept private. We saw that staff were empathetic in their dealings with patients.

The reception staff dealt with incoming calls and made outgoing calls from within the enclosed reception front desk area. Therefore, when patients contacted the practice they could be assured that their call was not inappropriately overheard. When patients approached the front desk reception area they could request to speak with the staff in a private room.

The nurse's consultation and treatment room had privacy curtains. We saw that doors were closed during patient appointments. Notices were displayed in the reception area advising patients they could have a chaperone present during their consultation if they so wished. However, we found that the GP's examination room was too small to accommodate a chair or wheelchair. There were no privacy curtains in place as there was no space available for these. When patients were examined in this room the patient would have to get off the couch once ready and open the door if it was locked. The GP informed us they ordinarily waited outside of the examination room and knocked to ascertain if the patient was ready to be examined in order to maintain patient privacy. In the event that a wheelchair user required examination the GP would opt to utilise the nurses' consultation room which was not ideal if patients were also booked to visit the nurse. The practice informed us they would seek advice regarding the GP examination and consultation room to ascertain whether changes could be implemented to improve this room. The premises were purpose built within a health centre (a 1970's construction). The practice rented the building from Staffordshire & Stoke-on-Trent Partnership Trust.

The practice computer system included notes on patient records to alert staff to patient needs that might require particular sensitivity. For example, learning disability or recent bereavement.

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

The patient survey information we reviewed showed that the majority of patients responded positively to questions about their involvement in planning and making decisions about their care and treatment, but there was room for improvement. For example, data from the national patient survey July 2014 found that only 61% of respondents said the GP was good at explaining tests and treatments compared with the CCG (regional) average of 81%. The results from the practice's own satisfaction survey completed in February 2014 and completed by 52 patients showed that on average 88% reported high levels of satisfaction with various aspects of their GP consultation. The practice was aware of the results and had action plans in place to address the shortfalls which had been identified.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Good

# Are services caring?

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

The practice survey conducted by the Patient Participant Group (PPG) showed that on average 96% of the respondents had reported high levels of satisfaction (good, very good, excellent) with various aspects of their nurse consultations. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Multi-disciplinary palliative care meetings were held on a quarterly basis to discuss the needs of those patients approaching the end of their life. Systems were in place to appropriately prioritise support required. Patient preferences were shared only with appropriate healthcare partners to ensure they were met, for example, out of hours services. Patients described the confidence and trust they had in the practice staff in that they had been treated with sensitivity and staff were empathetic.

Notices in the patient waiting room and patient website also told patients how they could access a number of support groups and organisations. The PPG informed us that the practice had held a carers event 18 months earlier. This had been useful and well received by patients and the practice had suggested that this would be repeated in the future.

Staff told us that if families had suffered bereavement the practice GP would contact them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

Patients we spoke with confirmed they would be offered a same day appointment if there was an urgent need. For routine appointments patients spoken with found they could arrange a timely appointment to meet their needs.

We saw that interpreter services could be arranged for appointments and staff were aware of this service. Literature was available signposting patients to healthy activity programmes, therapeutic groups, and support groups such as Age Concern. An example of this was guidance for men on prostate specific antigen (PSA) testing. PSA is a protein produced by the prostate.

The practice had an active patient participation group (PPG) who met regularly and minutes were taken of these meetings. We spoke with two members of the PPG who informed us they had had no concerns in respect of the practice. The practice had tried to recruit young people with families and patients from ethnic minorities to the PPG. The PPG were aware and endeavoured to encourage participation where possible. The GP had yet to attend a PPG meeting but planned to do so.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG reviewed the action plans and implementation with the practice manager or lead receptionist at their regular meetings for which we saw minutes.

The Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw evidence of attendance by the GP at various meetings and training events where this had been discussed. We saw that the practice had a CCG devised Quality Improvement Framework (QIF) with agreed actions to implement service improvements and manage delivery challenges to its registered patients. For example the CCG had determined from their data that 72.8% of all deaths in Stoke-on-Trent occurred as the result of three main causes; cancer (31.7%), circulatory disease (25.1%) and respiratory disease (16.0%). To address these issues all practices signed up to the CCG QIF. The QIF looked at what improvements needed to be made, for example in the area of blood pressure control. We saw that two audits were completed by the practice GP on blood pressure control measures in 2013 and 2014. The result had demonstrated the measures put in in place reduced the numbers of patients with a specified level of high blood pressure reading.

**Tackling inequity and promoting equality**

Staff had awareness of equality and diversity. The practice had recognised the needs of different groups in the planning of its services. The new patient list was open and staff were able to offer appointments to new patients, including patients with no fixed abode. The practice had access to online and telephone translation services and the GP spoke six languages.

The premises were purpose built within a health centre (1970's construction) and the practice was tenants of Staffordshire & Stoke-on-Trent Partnership Trust. The premises had been adapted to meet the needs of people with disabilities. There were accessible disabled toilet facilities and the practice was at ground floor level. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The practice manager informed us they had also purchased a raised chair for patients with reduced mobility. The practice had appropriate baby changing facilities. However, the GP examination room was not accessible to wheelchair users. The GP and practice manager informed us that the nurse consultation room was used as an alternative when required as this was wheelchair accessible. We discussed this with the practice who informed us they would discuss this with the appropriate department.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training during their induction and we saw that one of the nurses had completed further training in 2011.

Clinical staff had awareness of the NHS Stoke-On-Trent's Clinical Commissioning Groups' Equality Delivery Strategy 2012-2015. This was designed to tackle current health inequalities, promote equality and fairness and establish a culture of inclusiveness.

Public Health England's data found that the practice's average male life expectancy was 74.2 and female life expectancy 80.1, compared less favourably to the CCGs

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

male life expectancy of 76.9 and female life expectancy of 80.6. Life expectancy for both men and women was lower than the England average in both the CCG and the practice. We saw that the nurses held a number of regular clinics at the surgery to review for example chronic disease management, immunisation and vaccination smoking cessation and diabetes to provide health promotion information and advice.

### Access to the service

The practice was purpose built and was visibly clean and well maintained. There was a car park with dedicated disabled bays closest to the door. Corridors and doorways were wide enough to accommodate wheelchair access. The reception areas were spacious and well furnished with ample seating.

The practice opened Monday and Friday from 8am to 6.30pm and Tuesday and Wednesday from 8am to 7pm, it closed at 2pm on Thursdays. We discussed with the practice how they met the needs of the working age population, as the largest percentage of the practice population, 69.2%, were of working status, either paid work or in full-time education. The practice's extended opening hours enabled six additional appointments over a two day period. Patients with mental health needs including patients with a learning disability and those with complex medical conditions had longer appointments made available. We were informed that this was regularly reviewed to ensure they could meet the needs of their registered patients. None of the patients spoken with, the PPG, or the 25 CQC comment cards received suggested that obtaining urgent appointments had been problematic. Home visits and urgent same day appointments were available every day.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice manager showed us the complaints summary from their annual review of complaints. There were three complaints recorded both clinical and non-clinical. They also compared trends between this and the previous years' complaints. We saw that complaints were fully investigated and actioned or escalated where appropriate to do so.

We saw that information was available to help patients understand the complaints system including how to make a complaint. Patients we spoke with said should they wish to make a complaint they would read the information leaflet or approach the reception staff for advice and further information. None of the patients spoken with had needed to make a complaint.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice had a very clear vision in respect of staff roles, responsibilities, staff succession planning, career progression, education and training. This vision was clearly displayed in the GP and nurses consultation rooms. Their vision was to work in partnership with patients and staff to provide the best Primary Care services possible working within local and national governance, guidance and regulations. The practice also aimed to provide its patients with a quality personal health care service in line with the best NHS Primary Care standards.

Staff told us about the various meetings they attended to help keep them up to date with any new developments, professional updates and of any medical devices alerts or concerns. Staff knew what their responsibilities were and told us they wanted to continue to provide a good service for patients and were enthusiastic about their contribution.

We saw evidence that showed the practice worked with the CCG to share information, monitor performance and implement new methods of working to meet the needs of local people where appropriate to do so.

GPs attended various local health meetings and shared information appropriately externally and with their staff team. Staff engaged with multi-disciplinary team working and had awareness of the Community Integrated Local Care Teams (ILCT). The local Partnership NHS Trust launched ILCT to ensure patients living in Staffordshire were better supported to remain healthier and independent. The nursing and adult social care teams support frail, older people and those living with long term conditions such as asthma, diabetes, heart failure and kidney disease, providing care before a crisis occur. The local CCG suggested that 10% of patients would avoid hospital admission if managed with early evaluation through the ILCT. We saw in the practice meeting minutes that the practice engaged with the multidisciplinary team in respect of their patients and there was evidence of attendance at ILCT meetings with the Community Matron (CM).

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a random selection of policies and procedures, such as recruitment, health and safety and confidentiality. All those seen were up to date or had a set date for review. We saw that staff had during their induction confirmed that they had read the practice policies.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice was co-located with another GP practice. We saw that the practice had the opportunity to measure its service against others and within the CCG and to identify areas for improvement. For example the practice had recognised the need to improve the numbers of NHS health checks they completed. This was reiterated by the practice manager and GP and progress was reviewed at their regular staff meetings. The practice also offered a shingles vaccination programme for 70 and 79 year olds. We saw that up to November 2014 there had been an 83% response which included patients who chose to decline.

Individual aspects of governance such as complaints, risk management and audits within the surgery were allocated to appropriate staff. The practice submitted governance and performance data to the CCG.

The GP had completed a number of clinical audits, acted on findings and implemented changes where indicated. We found that the format used for the significant event audits for example could be developed further but the content demonstrated reflective practice. The practice was co-located with another practice and staff worked for both practices; they held regular joint meetings and learning was shared from each practice.

### Leadership, openness and transparency

Staff told us that there was an open culture within the practice. We saw from minutes that team meetings were held regularly, at least monthly. Staff told us they had the

# Are services well-led?

Good

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

opportunity and were happy to raise issues at team meetings. We saw that audits and checks took place to monitor the quality of services provided and that the findings were cascaded to staff and acted upon.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment, training and induction policy which were in place to support staff. Staff we spoke with knew where to find the practice policies if required and that paper copies could be located by the practice manager should the need arise.

Practice seeks and acts on feedback from its patients, the public and staff

We saw from minutes of meetings that staff members attended role appropriate meetings and contributed to the running of the practice. Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered. They were aware of what was meant by whistleblowing and told us they knew who they could go to for support.

The 25 CQC comment cards received confirmed that patients felt involved in decisions about their care and treatment. The patient participation group gathered information in response to patients' comments to enable the surgery to listen, act and respond appropriately to local concerns.

### Management lead through learning and improvement

We saw that regular appraisals took place. Staff told us that the practice was very supportive of training and that they had events where guest speakers and trainers attended.

There was a clear focus and desire to achieve the best possible outcomes for patients. The practice operated an open culture and actively sought feedback and engagement from staff, patients and the CCG all aimed at maintaining and improving the service.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings to ensure the practice improved outcomes for patients.