Cedar Practice

Quality Report

John Scott Health Centre
Green Lanes
Spring Park Drive
London
Tel: 020 7690 1151
Website: http://www.cedarpractice.co.uk

Date of inspection visit: 11 February 2015
Date of publication: 28/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cedar Practice on 11 February 2015. Overall the practice is rated as good.

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

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

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

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

Action the provider SHOULD take to improve:

Summary of findings

- Ensure Disclosure and Barring Service (DBS) checks are undertaken for staff who undertake chaperone duties at the practice.
- Ensure staff are made aware of what to do if the fridge temperature is out of range.
- Ensure that nursing staff receive Level three training in child safeguarding.
- Implement monitoring systems to evidence staff have read and understood governance policies.

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. Staff understood and fulfilled their responsibilities to raise concerns, to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Significant events were discussed routinely at both clinical and practice meetings. For example, 10 patients were vaccinated with water instead of their BCG vaccine to treat tuberculosis. The error was quickly identified and all 10 patients were recalled to be vaccinated and a formal apology was given to patients. The event was discussed with all clinical staff and learning and development was documented and shared amongst the clinical staff team.

There was enough staff to keep patients safe. The practice nurses and the healthcare assistant received regular updates to equip them with the skills and knowledge to fulfil their job role. The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Suitable systems were in place for staff recruitment, infection control, and safeguarding and medicines management.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Alerts were discussed at clinical and practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff were committed to working collaboratively and people who had complex needs were supported to receive coordinated care. There were efficient ways to deliver more joined up care to patients. These included assessing mental capacity and promoting good health. The continuing development of staff skills, competence and knowledge were recognised as integral to ensuring high-quality care. Staff were proactively supported to acquire new skills and share best practice. We found staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff appraisals and personal development plans were in place for all staff.

Summary of findings

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual physical health check. Similar mechanisms for identifying 'at risk' groups were used for patients who were carers, obese, experiencing mental ill health and those receiving end of life care. These groups were offered further support in line with their needs and were offered advice on support networks.

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 they were involved in decisions about their care and treatment. The data from the GP Patient Survey 2014 told us patients had confidence in the clinical staff they saw. The majority of patients said they had confidence and trust in the last GP they saw or spoke to and said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with most stating the GP was good at listening to them. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness, respect and maintained confidentiality. Training was provided in a number of areas to staff on how to deal sympathetically with all groups of vulnerable people. This included training for clinical staff in mental health, depression, domestic violence, learning disabilities and female genital mutilation.

The practice website offered patients information as to what to do in time of bereavement and also referred them to a local counselling service. A patient we spoke with confirmed they were referred and had used this service.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice responded quickly to issues raised and learned from 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

Summary of findings

obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. Patients were also provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

Are services well-led?

Good

The practice is rated as good for being well-led.The practice had a vision which was in the form of a mission statement to be patient centred, listen and be responsive. Not all staff were aware of the practice's mission statement but all knew and understood what their responsibilities were in relation to providing a good quality service. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. The patient participation group (PPG) was established and feedback from the group was always acted on. 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. Older people were cared for with dignity and respect. The practice was responsive to their needs, and there was evidence of working with other health and social care providers to provide safe care. We found that older patients identified at risk of isolation were discussed at monthly clinical meetings as well as multi-disciplinary meetings to monitor their care and address the support they required as necessary. Patients over 75 years old who were on the avoidable hospital admissions register were given a separate number to call the practice to enable them to get through to the practice faster. Home visits were also made to older patients. There was evidence of learning and sharing of information to help improve care delivery. There were structured and meaningful discussions in meetings to resolve issues in a time-bound and effective manner.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions There was evidence of effective and responsive care to patients with long term conditions (LTCs). Clinical staff had the knowledge and skills to respond to the needs of patients with cardiovascular diseases, diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD). Patients with long term conditions requiring repeat prescriptions had regular medication reviews.

There was a palliative care (end of life) register and patients on the register were discussed at the monthly palliative care meetings. The GP partner we spoke with used national standards for the referral of patients with chronic obstructive pulmonary disease and patients were referred within three weeks to pulmonary rehabilitation. Patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. Longer appointments were also available for people who needed them, for example patients with long-term conditions were seen for up to 45 minutes by the practice nurse.

Families, children and young people

Good

The practice is rated as good for care of families, children and young people. The practice was responsive to the needs of this group and staff said calls involving young patients were given urgent priority.

Summary of findings

There were suitable safeguarding policies and procedures in place, and staff we spoke with were aware of how to report any concerns they had. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Records demonstrated good liaison with partner agencies such as the police and social services. Clinical staff attended children protection case conferences and reviews where appropriate. The practice offered a full range of immunisations for children, which included travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse. Appointments were made available outside of school hours for children and young people and we saw that premises were suitable for children and young people. Young people could speak to staff in private and a sexual health clinic was available to these patients.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care working-age people (including those recently retired and students). There were a variety of appointment options available to patients such as telephone consultations, on-line booking and extended hours. To assist working age patients in accessing the service there was also a text message reminder for appointments and test results. The practice was performing well in undertaking cervical smear examinations and performance for cervical smear uptake was at 76%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. The uptake for health and blood pressure checks for working age patients was high and the practice offered NHS Health Checks to all its patients aged 40-75.

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. Patients attending the practice were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening. The practice had policies in place relating to the safeguarding of vulnerable adults and whistleblowing. Staff we spoke with were aware of their responsibilities in identifying and reporting concerns.

Summary of findings

Patients with a learning disability were supported to make 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 and had a section stating the patient's preferences for treatment and decisions. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual physical health check. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice website offered patients information as to what to do in time of bereavement and referral arrangements were in place with a local counselling service.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were told carers could also access the advocacy service available at the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice provided a caring and responsive service to people experiencing poor mental health.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice held monthly meetings with a consultant psychiatrist to discuss all patients on their register experiencing poor mental health. There were 73 patients on the register and we saw meeting minutes discussing patients' care plans and treatment options. There was a clinical psychologist at the practice one afternoon a week for patients to access and an alcohol advisor who was from a local alcohol recovery centre. The practice also worked closely with the local community mental health team. These patients could also access the citizen's advice bureau service which also visited the practice once a week.

An advocacy service was provided, which was advertised in the reception area to support patients in vulnerable circumstance and those suffering with poor mental health. All clinical staff had received training in the Mental Capacity Act 2005 and were able to demonstrate an understanding of key parts of the legislation and describe how they implemented it in their practice.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014 and a survey of 177 patients undertaken by the practice between December 2013 and January 2014. These highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 122 patients who completed the survey, 89% said they had confidence and trust in the last GP they saw or spoke to and 92% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with 79% practice respondents saying the GP was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment card described their experience with the GP they saw as negative but we did not find any common themes to this.

Areas for improvement

Action the service SHOULD take to improve

- Ensure Disclosure and Barring Service (DBS) checks are undertaken for staff who undertake chaperone duties at the practice.
- Ensure staff are made aware of what to do if the fridge temperature is out of range.
- Ensure that nursing staff receive Level three training in child safeguarding.
- Implement monitoring systems to evidence staff have read and understood governance policies.

Cedar Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Cedar Practice

Cedar Practice operates from John Scott Health Centre, Green Lanes, Spring Park Drive, London, N4 2NU. The practice provides NHS primary medical services to just over 6,000 patients in the City and Hackney area. It comprises of three full time female GPs and one full time male GP, a practice nurse, a healthcare assistant, a practice manager and a small team of administrative staff. The practice nurse was also a qualified independent prescriber.

The appointments telephone line was available from 8.00 am to 6.30 pm, Monday to Friday. To assist working age patients in accessing the service there was an easy to use online booking system, text message reminders for appointments and test results. Extended hours appointments between 7.00 am and 8.00 am on Mondays, Tuesday and Fridays were also available. Urgent appointments were available each day and GPs also completed telephone consultations for patients.

The practice had a GMS contract (General Medical Services agreements are locally agreed contracts between NHS England and a GP practice) and provided a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning clinic, and contraception services.

The out of hours services were provided by a local deputising service to cover the practice when it is closed.

The practice had a higher than average percentage of patients between the 45-49 year age group.

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.

Why we carried out this inspection

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

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

How we carried out this inspection

To get to the heart of patients' experiences of care 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)

Detailed findings

- 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 and asked other organisations to share what they knew. We carried out an announced visit on 11 February 2015. During our visit we spoke with a range of staff such as three of the GP partners, practice nurses, healthcare assistant, practice manager and administrative staff. We spoke with four patients. We reviewed personal care or treatment records of patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety including reported incidents, national patient safety alerts and comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff promptly reinstated district nurse visits after identifying a patient had not been visited by the district nurse for two weeks to have their catheter washed out and had previously had three hospital admissions with a blocked catheter. The incident was discussed with clinical staff and the district nurses involved and a review of the system was initiated.

We reviewed safety records, incident reports and minutes of meetings for the last one and half years. This showed the practice had managed these consistently and showed 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. There were records of significant events that had occurred during the last one and half years and we were able to review these. Significant events were a standing item on the agendas for both clinical meetings which took place twice a month and the monthly practice meeting, to review actions from past significant events and complaints. The practice had been open and honest when dealing with and recording such events and every effort was made to learn from them. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on their practice intranet and sent completed forms to the practice manager. She showed us the system she used to manage and monitor incidents. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a 10 year old patient had been prescribed an adult dose of Paracetamol and Ibuprofen. The error was identified by the pharmacist and the prescription was promptly amended. The incident was discussed at a clinical meeting with all the four GP partners and learning was shared, which included the importance of checking patient details before and after issuing a prescription, as the error was due to the child and their parent sharing the same name. Another event included 10 patients being vaccinated with water instead of the vaccine to prevent tuberculosis. The error was quickly identified and all 10 patients were recalled to be correctly vaccinated. A formal apology was given to patients. The event was discussed with all clinical staff and learning and development was documented and shared amongst the clinical staff team.

National patient safety alerts were disseminated by the practice manager to all practice staff as well as by email to all clinicians. We were shown the protocol which was very thorough. Staff we spoke with were able to give examples of recent alerts. A recent alert sent by NHS England in December 2014, regarding the insulin auto pen injection device was discussed with all clinical staff and sent to them by email. Alerts were also discussed at monthly practice meetings to ensure all staff were aware of any that were relevant to their practice and where they needed to take action. We saw minutes of staff meetings which evidenced this.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. Two GP partners each took a lead on safeguarding adults and children within the practice. All staff we spoke to were aware who these leads were and who to speak to if they had a safeguarding concern. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff on the shared computer system and displayed in staff offices.

All four GPs had been trained to Level three in child protection, the practice nurses to Level two and all other non-clinical staff to Level one. They demonstrated they had the necessary training to enable them to fulfil this role. In line with intercollegiate guidance, the practice should train

clinical nursing staff to Level three in child safeguarding. The practice had a register for vulnerable adults and children. There were 14 children on the practice's child protection register and 41 children identified as vulnerable. Children at high risk received quarterly home visits and care plans were updated following routine or emergency visits. There was also a register of vulnerable children requiring immunisations.

Vulnerable patients were discussed routinely at clinical meetings. GPs and the practice nurse were appropriately using the required codes on their electronic case management systems to ensure risks to children and young people who were looked after and on child protection plans were clearly flagged and reviewed. Clinical staff attended children protection case conferences and reviews where appropriate. Reports were sent if they were unable to attend and scanned into the patient's medical records. The records demonstrated good liaison with partner agencies such as the police and social services.

There was a system for reviewing repeat medications for patients with co-morbidities/multiple medications, which was also monitored by the Quality Outcomes Framework (QOF), a system the practice completes to monitor their performance and in return for good practice received payment. There were 623 patients with more than four repeat prescriptions and 84% were monitored and reviewed through QOF. There were 1386 patients on repeat medication and 65% of those had received a review. In addition, those patients on anti-psychotics were closely monitored and received annual health and medication reviews.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice nurse, a healthcare assistant and member of the reception team had been trained to chaperone. They understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. One non clinical member of staff who acted as a chaperone had not had a completed Disclosure and Barring Service (DBS) check, which enables employers to check the criminal records of employees. However, the practice had completed a risk assessment and informed us that the member of staff would not be authorised to chaperone a patient on their own.

Medicines management

We checked medicines stored in three medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. Fridge temperatures were taken each day and an audit trail was kept. We did note that the policy informing staff what to do if the fridge temperature was out of range was not detailed. The practice nurse informed us that the policy was in the process of being updated.

Processes were in place to check medicines were within their expiry date and suitable for use. Medicines were checked monthly and an audit trail was maintained. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of appropriately.

The practice nurse and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the practice nurse and the health care assistant had received appropriate training to administer vaccines, for example clinical immunisations and vaccines updates. The practice nurse was qualified as an independent prescriber. She told us she received regular supervision and support in her role from the GP's as well as updates in the specific clinical areas of expertise for which she prescribed. Peer reviewing was also taking place with other practices in the area around prescribing data and we saw peer review minutes of meetings to evidence this.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. The GP advisor supporting us on the inspection checked five anonymised patient records which confirmed that the procedure was being followed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice also issued prescriptions through their online system which were directly sent to the patient's specified pharmacy. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and were kept securely at all times in a secure cupboard.

Good

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Disposable curtains were in place in each treatment room and were replaced every six months.

The practice had two leads for infection control who were the practice nurse and the practice manager who had undertaken training to enable them to provide advice on the practice infection control policy and deliver staff training. All staff received induction training about infection control specific to their role and received annual updates. Updates were also discussed at practices meetings and we saw the minutes of these meetings confirming this . We saw evidence that the practice had carried out infection control audits for the last three years 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 to control 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 displayed in staff and patient toilets, as well all treatment rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had completed a legionella test on a yearly basis to reduce the risk of infection to staff and patients. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Weekly cleaning schedules were in place and written records were kept of this. Cleaning of the practice was completed everyday by an external cleaning contractor.

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.

We saw evidence of calibration of relevant equipment completed on an annual basis such as the vaccine fridge, spirometer, weighing scales, defibrillator and blood pressure devices.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. They told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Priority was given to provide cover in house however as a contingency the practice kept a locum GP contact list.

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. There were checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Annual audits were also completed for new medicines, controlled drugs and waste management. Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. The practice had a health and safety policy. Health and safety information was displayed around the practice and the practice manager was the identified health and safety representative.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or

medical emergencies. For example, patients with long term conditions whose health deteriorated were given a call back by the GP on the same day. There was also a dedicated on call mobile number where these patients could bypass the surgery number in the case of an emergency and speak to a GP directly. This process was also available to the parents or guardians of acutely ill children and patients with pregnancy related complications. One of the GPs was the practice antenatal lead. In addition there were two midwives who held clinics at the practice, one of which was a public health midwife and was responsible for all teenage mothers within the practice, to provide extra support and care to these patients.

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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff knew the location of the equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Monthly and annual processes were 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.

A business continuity plan was in place to deal with a range of emergencies that impacted on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also informed staff of what to do and who to contact if they experienced loss of the computer system, telephones, electricity or water.

The practice carried out annual fire risk assessments to maintain fire safety. All fire equipment such as the fire alarm was serviced yearly and the staff team practised weekly fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice and clinical meetings where new guidelines were disseminated, the implications of it for the practice's performance considered, patients were discussed and the required actions agreed. Discussions at clinical meetings highlighted vulnerable house bound patients and the practice used a risk assessment tool to generate a list of 38 high risk patients. The staff we spoke with and the evidence we reviewed confirmed that assessments were designed to ensure that each patient received support to achieve the best health outcomes for them. The practice also monitored the number of home visits each patient received. In addition there was an education cascade generated at each meeting.

The GPs told us they lead in specialist clinical areas such as diabetes, safeguarding, medication management, maternity, antenatal care; well women health checks and, child health and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of sexual health, respiratory disorders and vaccines. Our review of the clinical meeting minutes and staff training records confirmed this happened.

The practice had completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and a regular review. We checked four medical notes of hypertensive patients and noted they all had received a medication review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The practice was providing a long term conditions local enhanced service and their performance was compared to other practices in City and Hackney's Clinical Commissioning Group. The practice had met all the required standards and was a high performer for 15 out of the 18 standards.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

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) which is a national performance measurement tool. The practice showed us eight clinical audits that had been undertaken in the last two years. Two of these were completed audits which were on repeat prescribing and warfarin prescribing. The practice was able to demonstrate the changes they made since the completed audits cycles. For example, the first cycle of looking at repeat prescribing was completed in September 2013 and the second cycle was completed in January 2014. The audit highlighted areas for improvement in reducing the numbers of repeat dispensing, red drugs which are considered to be specialised medicines and increase the number of medication reviews. The improvements were implemented and in January 2014 the practice recorded an increase in the number of medication reviews and decrease in repeat dispensing.

The second completed audit reviewed warfarin prescribing. A total of 23 patient's medical notes were examined in the first part of the audit in September 2013. The main areas for

Good

Are services effective?

(for example, treatment is effective)

improvement were for all prescribers to use the warfarin template, when prescribing the medicine, to ensure this was scanned into the patient's medical notes, and to encourage the safe prescribing of warfarin in order to reduce the risk of harm caused by the drug. During the second part of the audit, it was noted clinical staff had increased the use of the template, were providing patient education when their INR(International Normalised Ratio) was out of range, were monitoring and documenting this in patients' medical notes and had completed annual reviews for 100% its patients involved in the audit.

Another audit look at the long term use of oral steroids and the increased risk of developing osteoporosis were examined. A total of 18 patients using more than 5mg of Prednisolone, (a synthetic steroid) for three months were looked at. Ten patients had not had a DEXA scan, which is a special type of X-ray that measures bone mineral density (BMD). A re-audit was done a year later and all the action points and key findings from the first part of the audit had been acted upon. Other incomplete audits looked at the management of long term conditions, chronic kidney disease, individual cancer referrals, two week referrals, the prescribing of Tamoxifen, a drug used to treat breast cancer and infertility in women and Disease Modifying Antirheumatic Drugs.

We saw an audit regarding the prescribing of Tamoxifen as a result of a significant event at the practice which highlighted that a patient had been on the medicine for longer than the recommended time. The British National Formulary (BNF) states that Tamoxifen should be prescribed for 5 years. Following the audit the practice decided to place an alert on each patient's computerised medical notes stating the date they started the medicine.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. We looked at the medical records for two diabetic patients and found appropriate medication had been reviewed and prescribed. The IT system flagged up relevant medicine alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Out of 1744 patients over the age of 45 years who required a blood pressure check, 88% had been seen and out of 1593 patients who required a smear test in the last five years, 80% had been seen, which was higher than the national average. The practice was on target for annual medication reviews for patients with diabetes and had seen 91% of its patients.

Patients aged between 18-25 were offered opportunistic chlamydia screening and smokers were offered smoking cessation advice. Patients were referred to a local stop smoking service run by the local GP Confederation. QOF data showed us that 1968 patients were identified as smokers and 1% had stopped smoking in the last 12 months. There were 350 patients on the asthma register and 108 of those patients had a medication review. There were 293 patients on the diabetic register and 126 of those patients had received a medication review within the last 12 months. The practice met all the minimum standards for QOF in diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD).

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register of 14 patients and had monthly internal as well as external multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staff included four full time partner GPs, one practice nurse, one healthcare assistant, a practice manager and a team of administrative staff. There was one vacant practice nurse post. We reviewed staff training

Good

Are services effective?

(for example, treatment is effective)

records and saw that all staff were up to date with attending mandatory training courses such as annual basic life support, safeguarding adults and chaperoning. All GPs were up to date with their yearly continuing professional development requirements and three had been revalidated in January 2015 and one was due their revalidation in July 2015. This is a process where every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with clinical staff confirmed that the practice was proactive in providing training and funding for relevant courses, such as cytology, contraceptive and sexual health updates, COPD training and training in managing eczema in children and babies, which the practice nurse had attended. Some of the staff team had also received training in domestic violence, mental health and learning disabilities updates including the GPs and healthcare assistant. A member of the reception team had been supported to train as a healthcare assistant and was currently working in this role at the practice.

Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results, was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice worked with other service providers to meet patient needs and manage complex cases. It held clinical multidisciplinary team meetings twice a month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, community psychiatric nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. There was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals; the practice used the Choose and Book system, which enabled patients to choose which hospital they would like to be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident & Emergency (A&E) department. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E.

The practice had systems to provide staff with the information they needed. Staff used electronic patient records to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this legislation. All clinical staff had received training in the Mental Capacity Act 2005. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. These processes highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. A record of patients with a Do Not Resuscitate (DNR) status were kept on a register at the practice.

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia were supported to make 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 and contained a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us five care plans that had been reviewed in the last year. In total, there were 33 patients diagnosed with dementia and 97% had received a dementia assessment. 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 helped clinicians to identify children aged under 16 who had the legal capacity to consent to medical examinations and treatment.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the Clinical Commissioning Group to discuss the implications of and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 38% of patients in this age group took up the offer of the health check. Patients were followed up within two weeks if they had risk factors for disease identified at the health check and were then scheduled for further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual physical health check. There were 24 patients on the learning disability register and 12 of these patients had received an annual review this year. Similar mechanisms of identifying 'at risk' groups were used for patients who were identified as carers, as obese and those receiving end of life care. These groups were offered further support in line with their needs and offered advice on support networks.

The practice's performance for cervical smear uptake was at 80%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, which included travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

Young people were signposted towards sexual health clinics as well being offered advice on contraception.

The uptake for health checks including a blood pressure check for working age patients was at 88% with a patient count of 1744 patients.

The practice registered patients who were homeless and had registered individuals residing at a local bed and breakfast for the homeless. The practice held monthly meetings with a consultant psychiatrist to discuss all patients on their register experiencing poor mental health. There were 73 patients on the register and we saw meeting minutes discussing patients' care plans and treatment options. There was a clinical psychologist at the practice one afternoon a week for patients to access and an alcohol advisor who was from a local alcohol recovery centre. The practice also worked closely with the local community mental health team. These patients could also access the citizen's advice bureau service which also visited the practice once a week.

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 GP Patient Survey 2014 and a survey of 177 patients undertaken by the practice between December 2013 and January 2014. These highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 122 patients who completed the survey, 89% said they had confidence and trust in the last GP they saw or spoke to and 92% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with 79% practice respondents saying the GP was good at listening to them, describing their experience as very good.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment card described their experience with the GP they saw as negative but we did not find any common themes to this.

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

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped patient information to be kept private. Patients could speak to reception staff in a private room and notices were displayed in the reception areas informing patients of this option.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would conduct an investigation and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations. Panic alarms were situated behind the reception desk and in each treatment room for staff to use in the event of an emergency.

Training was provided in a number of areas to clinical staff on how to deal sympathetically with all groups of vulnerable people. This included training in mental health, depression, domestic violence, learning disabilities and female genital mutilation.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed and comment cards we received showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the GP Patient Survey showed 71% of respondents said the GP involved them in care decisions and 79% of patients felt the GP was good at explaining treatments. The results from the practice's own satisfaction survey completed in January 2015 by 41 patients all stated they were confident in the staffs' ability to provide care and all were happy to see their GP again.

Four patients we spoke to on the day of our inspection who were also members of the Patient Participation Group (PPG), told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on CQC comment cards was also aligned with these views.

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

Are services caring?

service was available. The practice reception desk was equipped with a hearing loop to support patients with a learning disability and staff had access to sign language services.

We saw evidence of care planning and patient involvement for adults at risk of an emergency admission. This included 120 adult patients who all had a named GP and a care plan which had been agreed and reviewed. A case management register was also kept of all children who had an unplanned admission to the accident and emergency department within the last 12 and three months, to ensure they had a follow up consultation. The practice told us they used the Department of Health's 'You're Welcome' criteria to provide young people friendly health services.

The practice had a list of vulnerable house bound patients. The Clinical Commissioning Group (CCG) also generated a list of high risk patients. We were informed that patients with long term conditions were supported in the practice by the practice nurse and the health care assistant. Weekly, nurse led clinics took place for patients with long term conditions such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease (COPD).

Patient/carer support to cope emotionally with care and treatment

The practice website offered patients information as to what to do in time of bereavement and also referred them to a local counselling service. A patient we spoke with confirmed they were referred and had used this service.

Notices in the patient waiting room, advised patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and the practice assessed carers' needs and kept a register of these individuals.

We saw that older patients identified as at risk of isolation were discussed at clinical meetings as well as to address the support they required.

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 practice used a risk assessment tool, which helped clinical staff to detect and prevent unwanted outcomes for patients and a scorecard system, to compare performance with other practices. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

We found the practice to be involved in actively promoting its Patient Participation Group (PPG) which included 21 members in its face-to-face group, who in 2014 met on a bi-monthly basis and had 8 members in its virtual PPG. As part of feedback from members who stated they were unable to attend meetings during the day, the practice had organised evening meetings for these members. The virtual PPG received correspondence, meeting minutes, newsletters, invites by email and post. The practice website and posters in the reception area was advertising for more patients to join and gave them information on what was involved. We spoke with four members of the PPG who said they were very happy with the efforts the practice had taken to involve patients in their care. They felt that their concerns were listened to and suggestions were always implemented.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We saw the practice had identified the numbers of patients on the learning disability register, those experiencing poor mental health, patients who were also carers, children and adults on the vulnerable risk register and patients with dementia. There was a palliative care register and the practice had regular monthly palliative care meetings to discuss patients, their families care and support needs. The needs of these different groups were discussed at the range of meetings that took place at the practice with internal and external clinical staff.

The practice had access to both face to face and telephone interpreter services.

The practice had not provided equality and diversity training to its staff team. Although, this training had not been provided, equality and diversity was regularly discussed at staff appraisals and practice team meetings.

The premises and services had been adapted to meet the needs of people with disabilities and there was

pram and wheelchair access throughout the premises. As well as an accessible toilet there were also baby changing facilities. The practice was situated on the ground floor with all services for patients operating from this floor.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice worked closely with the local mental health team. A community psychiatric nurse visited the practice once a week as well as a consultant psychiatrist who visited once a month, offering specialist input to mentally ill patients. In the event of a patient experiencing a mental health crisis they were directed to the accident and emergency department or to the community mental health team.

Access to the service

The appointments telephone line was available from 8.00 am to 6.30 pm, Monday to Friday. To assist working age patients in accessing the service there was an easy to use online booking system, text message reminders for appointments and test results. Extended hours appointments between 7.00 am and 8.00 am on Mondays, Tuesday and Fridays were also available. Urgent appointments were available each day and GPs also completed telephone consultations for patients.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well through posters and leaflets available at the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available with a named GP, nurse or healthcare assistant for people who needed them, for example those with long-term conditions. Home visits were made to those patients who needed one, such as older patients and those with long term conditions.

The GP Patient Survey had a low percentage of patients who described their experience of making an appointment as good which was at 48% with 15% of patients describing the experience as very poor. Eight CQC comments we received were less positive about available appointments and there was a common theme to these. The practice had similar feedback from the own practice survey and had been responsive in providing better access to the practice for patients. The practice survey was purposely centred on the appointment system and customer services provided by the practice. Changes were implemented by the practice as result of the feedback received from patients regarding the concerns with the appointment system.

The members of the PPG also informed that a main area of concern for the group had been the appointment system which the practice had changed to improve patient accessibility. The group told us that an online appointment system was introduced which they described as 'excellent' and could access any of the services available at the practice, such a phlebotomy, physiotherapy, mental health services which saved time.

We saw results of the survey were given to all Patient Participation Group (PPG) members, were published on the practice website and displayed in the patient waiting area. The changes included better access to appointments for patients. This included, allowing patients to book routine appointments four weeks in advance, offering appointments within 48 hours, GP's continuing to provide telephone consultations for urgent medical needs between 8.00 am and 11.00 am and to book appointments as necessary. The practice continued to take non urgent telephone messages that GPs actioned within 48 hours. Appointments were made available outside of school hours for children and young people.

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 handled all complaints in the practice. Patients were also provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

We saw that information was available to help patients understand the complaints system such as posters displayed in the reception area. Four members of the PPG we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had recorded five complaints between April 2013 and March 2014. They were satisfactorily handled and were dealt with in a timely way which was in accordance with the practice's complaints policy. Each complainant was written to, discussing their complaint in detail and were invited to see the practice manager with an aim to resolve their complaint. All complaints were thoroughly recorded and we saw evidence of openness and transparency when dealing with complaints. All verbal complaints were recorded in writing to ensure they were not missed and were also responded to in writing.

The practice reviewed complaints on an on-going basis and completed an annual complaints review to detect themes and trends. As a result of the last review in 2014, the highlighted issues were discussed with the PPG and a review of the appointment system was initiated. Some staff members attended further refresher training in customer services, to refresh their skills in handling difficult situations and provide better communication to patients. Complaints were discussed at clinical and practice team meetings to ensure lessons were learned from individual complaints. We saw from the minutes that complaints were routinely discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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 manager informed us they had a vision which was in the form of a mission statement which was to be patient centred, listen and be responsive. Although the mission statement was documented and available for inspection, it had not been filtered down to staff and staff we spoke to other than the practice manager where not aware of it.

We spoke with six members of staff and they all knew and understood their responsibilities were in relation to providing a good quality service. They were aware of the needs of the local population and how the practice was meeting its needs.

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 and were also given to staff in the form of a handbook. We looked at 12 of these policies and procedures and there was not a system in place to confirm staff had read and understood the policies. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, safeguarding, medication management audits, health and safety, fire safety, information governance and patient complaints. We spoke with six members of staff who told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff were encouraged to learn and develop their careers.

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. This was reflected in the meeting minutes we reviewed.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice showed us eight clinical audits that had been undertaken in the last two years. Two of these were completed audit cycles, on repeat prescribing and Warfarin prescribing. The practice was able to demonstrate the changes resulting since the audits. The GPs told us clinical audits were often linked to medicines management information and safety alerts.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as risks to the building, staff, dealing with emergencies and equipment. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at GP partners' meetings and within team meetings.

The practice also had a health and safety policy. Health and safety information was displayed in the staff room for staff to see and the practice manager was the identified health and safety representative.

The practice held monthly practice meetings which discussed governance. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from meeting minutes that team meetings were held monthly and clinical meetings twice a month. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and recruitment policy, which were in place to support staff. They were detailed and provided appropriate guidance for staff. We were shown the staff handbook that was available to all staff, which included sections on equality, harassment and bullying at work. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through its practice patient surveys and complaints received. We looked at the results of their practice survey which was to examine concerns with the appointment system. As a result systems were put in place to improve patient access to appointments. We found the practice to be involved in actively promoting its Patient Participation Group (PPG)

Are services well-led?

Good

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

which included 21 members in its face-to-face group, who in 2014 met on a bi-monthly basis and had 8 members in its virtual PPG. We spoke with four members of the PPG who said they were very happy with the efforts the practice had taken to involve patients in their care. They felt that their concerns were listened to and suggestions were always implemented. The members informed us that a main area of concern for the group was the appointment system which the practice has now changed to improve patient accessibility. The group informed they now have an online appointment system which they described as 'excellent'. They informed us they could access any of the services available at the practice, such a phlebotomy, physiotherapy, mental health services which saved time.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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 thirteen staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the clinical and practice meeting agenda to review actions from past significant events and complaints. There was evidence that the practice learned from these and that the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.