The Ridgeway Surgery

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Ridgeway Surgery on 5 February 2015. The practice also provides services at a branch surgery at 275 Alexandra Avenue, Harrow. Patients registered with the practice may attend either surgery. On this occasion we inspected the main surgery and overall we rated the service at this location as Good.

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

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. There were processes in place to safeguard vulnerable adults and children.
- Patients' needs were assessed and care was delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned through personal development plans.
- Patients described staff as helpful, kind, efficient, gentle and caring and said they were involved in decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand.
- Patients were generally satisfied with the appointment system and found it easy to make an appointment.
- Staff felt the practice management team was supportive and they had opportunity and funding to attend training courses for professional development.
- The practice had a pro-active and enthusiastic Patient Participation Group (PPG) that was representative of the practice population.

Summary of findings

We saw some areas of outstanding practice:

- The pro-active involvement and commitment of the Patient Participation Group (PPG), the patient engagement activities organised by the group and the quarterly patient newsletter produced.
- Health information provided on the practice website for patients fasting during Ramadan.

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

The provider should:

- Maintain a risk log that records how identified risks have been assessed and progressed.
- Ensure that clinical waste bins stored outside the practice premises are kept securely at all times.

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, and to report incidents and near misses. Significant events were discussed at practice meetings to identify learning points and share these with all staff. There were processes in place to safeguard vulnerable adults and children including an alert system on vulnerable patients notes that was graded according to the severity of the risk. The practice adhered to their recruitment policy and there were enough staff to keep patients safe. There was a clear business continuity plan in place with risk assessments for potential disruptions to services and action plans to mitigate these risks. The practice had an infection control policy and conducted regular infection control audits with evidence of changes made to service as a result of these. The practice required improvement with regards to the cleanliness of the environment.

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. The practice had in-house peer review of referrals to secondary care to monitor and improve referrals. Completed clinical audits were performed regularly to monitor service and implement changes for improvement. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff understood the principles of assessing capacity and supporting patients to make their own decisions. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. For example, 90% of respondents to the National GP patient survey published in January 2015 said they would recommend the practice to some one new to the area and this was above the CCG average for the area. Patients described staff as helpful, kind, efficient, gentle and caring and said they were

Summary of findings

involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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. Patients we spoke with were generally satisfied with appointment system and this was reflected in the National GP patient survey with 80% of respondents describing their experience of making an appointment as good. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice held annual complaint review meetings to discuss learning points from each complaint and identify trends and themes.

Are services well-led?

Good

The practice is rated as goodfor being well-led. The practice had a pro-active and enthusiastic Patient Participation Group (PPG) that was representative of the practice population. They conducted regular patient surveys and held meetings with the practice team to analyse results and create action plans to address issues raised. They produced a quarterly newsletter and arranged regular educational talks and health promotion courses for patients to attend. The practice had a clear vision and values that included putting patients first and foremost, promoting safeguarding as everyone's role and education for all staff and patients. They had policies in place to govern activity and held regular management meetings to discuss governance issues and improving performance. The practice used Quality Outcome Framework (QOF) data and clinical audit to monitor performance and drive improvement. Staff received annual appraisal that included maintaining personal development plans. Staff told us the practice was supportive of their training needs and they had opportunity and funding to attend training courses. The practice was an accredited GP training practice and the GP trainee spoke highly of the support and education received at the 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 people. All patients over the age of 75 years had a named GP to co-ordinate their care. The practice had identified frail elderly patients at high risk of hospital admission and had achieved their target of completing 290 integrated care plans to co-ordinate their care and reduce admission risk. The practice was involved in a pilot initiative in which specially trained GP link nurses visited frail elderly patients in their own homes to assess and review their care needs. Home visit appointments were available for patients unable to attend the practice due to illness or immobility. The practice offered a full range of immunisations in line with national guidance and the uptake rates for flu immunisation was at average for the Clinical Commissioning Group (CCG) area.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. They offered nurse led management clinics for patients with long term conditions and a weekly GP led diabetes clinic with extended appointments for new patients. Patients with long term conditions were offered annual review including medication review. The practice used risk stratification tools to identify patients at risk of hospital admission and they had a programme to create integrated care plans to help manage and meet these patients' needs. The practice offered flu immunisation to at risk groups of patients in line with national guidance and uptake rates were in line with the CCG average. The practice had a section on their website which provided information and advice for patients with common chronic conditions fasting during Ramadan.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to safeguard vulnerable children including alerts on patients notes to inform staff if the there was a child protection plan in place. The practice maintained a list of carers including foster parents who may require additional support. The practice offered a full range of childhood immunisations in line with national guidance and uptake rates were in line with the CCG average. There was a system to follow for patients who did not attend immunisation appointments that included three reminder letters and then a personal phone call to discuss attendance by a member of staff who knew the family well.

Summary of findings

The practice had a section on their website for 16-25 years olds that offered health promotion advice. The practice had recently been approved to take part in a local scheme aimed at reducing admissions in children and young adults with asthma.

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). Extended hours opening was available at the practice on Mondays, Tuesdays and Wednesdays and at the branch surgery on Saturdays for patients who were unable to attend the practice during normal working hours. Telephone consultations could also be requested on the same day. Appointments and repeat prescriptions could be made online for those who found it difficult to attend the practice. Saturday immunisation clinics were offered for those who could not attend during the week. The practice ran a travel clinic and offered relevant travel vaccinations if required.

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. There were alerts added to patient notes to make staff aware of any specific requirements and extended appointments could be offered to patients who required translation services or those with hearing impairment. The practice kept a register of patients with learning disabilities and offered them annual health checks including medication review and blood tests. They also provided domiciliary assessment and annual health checks to patients with learning disabilities living in local specialised care homes. The practice kept a register of patients with drug missuse problems requiring specialist prescriptions. These patients had a named GP to maintain continuity of care. Three of the GPs had received specialist training in drug addiction and the practice had access to refer patients to a local drug centre.

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 worked with multi-disciplinary teams in the case management of people experiencing poor mental health. They engaged with the local community mental health team and a psychologist attends the practice on a weekly basis. The practice had implemented the local CCG dementia pathway and as a result the number of diagnoses had

increased. Clinical staff had attended recent CCG led dementia training to improve knowledge and awareness of the condition. We were told staff would opportunistically screen for memory problems and refer on to a local memory service if appropriate.	

Summary of findings

What people who use the service say

During our inspection we received 28 Care Quality Commission (CQC) comment cards that patients had completed and spoke with ten patients including six members of the patient participation group (PPG). Overall the feedback given was positive. The majority of patients spoke highly of the care they received and felt that all staff at the practice were helpful, polite and caring. Many of the patients had been with the practice for a long time and said they would recommend it to friends and family. This was similar to the findings of the national GP patient survey published in January 2015, which found that 89% of respondents described their overall experience of the practice as good and 90% said that they would recommend the practice to someone new to the surgery.

Two of the 28 CQC comment cards received mentioned the wait to be seen from appointment time could be long. This was also reflected in the National GP survey with only 51% of respondents reporting they usually waited 15 minutes or less after their appointment time to be seen. However, some of the patients we spoke with explained waiting times could be longer for particular GPs but that they did not feel this was a problem as they were receiving thorough assessments.

Areas for improvement

Action the service SHOULD take to improve

- Maintain a risk log that records how identified risks have been assessed and progressed.
- Ensure that clinical waste bins stored outside the practice premises are kept securely at all times.

Outstanding practice

- The pro-active involvement and commitment of the Patient Participation Group (PPG), the patient engagement activities organised by the group and the quarterly patient newsletter produced.
- Health information provided on the practice website for patients fasting during Ramadan.

The Ridgeway Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice manager and expert by experience who were granted the same authority to enter the practice premises as the CQC inspector.

Background to The Ridgeway Surgery

The Ridgeway Surgery is a well-established GP practice located in Harrow within the London Borough of Harrow and is part of the NHS Harrow Clinical Commissioning Group (CCG) which is made up of 35 GP practices. The practice provides primary medical services to approximately 14,500 patients. The practice has a branch surgery at Alexandra Avenue that is registered separately with the CQC. Patients registered with the practice may attend either surgery.

The practice holds a Personal Medical Services (PMS) contract (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services) and is commissioned for the provision of local enhanced services which include extended hours and minor surgery.

The practice team comprises of three male and three female GP partners, four female and one male salaried GPs, two female practice nurses, two female Health Care Assistants, one male practice manager, eight administration staff and twelve receptionists. The practice also employs a regular female locum GP. The practice is a training practice and hosts one female trainee GP registrar.

The practice opening hours are 8.00am to 6.30pm Monday to Friday. In addition extended hours are provided from 7.30am to 8.00am on Wednesday morning; from 6.30pm to 7.30pm on Monday and from 6.30pm to 7.10pm on Tuesday and Wednesday. Pre-bookable appointments with the practice nurse are available at the branch surgery each Saturday from 8am to 11am and from 1.00pm to 3.30pm. The out-of-hours service is provided by an alternative provider. Patients are directed when the practice is closed to NHS 111 advice line. The practice provides a wide range of services including minor surgery, checks for diabetes, chronic obstructive pulmonary disease (COPD), asthma review, INR monitoring and child health care. The practice also provides health promotion services including a flu vaccination programme, travel clinic and cervical screening.

The age range of patients is predominately 25- 64 years and the number of 25 - 39 year olds is greater than the England average. The practice patient population has a mixed ethnic profile.

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.

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.

Detailed findings

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.

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 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 met with NHS England, NHS Harrow Clinical Commissioning Group (CCG) and Healthwatch Harrow and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 5th February 2015.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, reception and administration staff. We also spoke with ten patients who used the service including six representatives from the practice patient participation group (PPG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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, a recent event involving a patient who fell at the practice was recorded and managed appropriately.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently during this period and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the year and we were able to review these. Significant events was a standing item on the monthly practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events. There was evidence that the practice had 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.

Staff used significant event audit forms to record incidents that included information on when the event occurred, the date it was discussed at the practice meeting, positive points, areas of concerns and action plans to improve practice. We tracked six incidents from the last year and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example a recent event when the temperature of the refrigerator that contained vaccinations had been out of range had been reported. The staff involved put measures in place to ensure the vaccines were not used and contacted the Health Protection Agency for advice and those considered to be unusable were disposed of accordingly. The practice arranged for the fridge to be serviced and continued to implement their policy of twice daily fridge temperature recordings.

National patient safety alerts were disseminated by email to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for example a recent alert about food thickeners had been circulated to all clinical staff via email.

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 that all staff had received relevant role specific training on safeguarding, for example GPs and nursing staff had received child protection training to level three and non-clinical staff to level one. 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 how to contact the relevant agencies in working hours and out of normal hours. The GPs we spoke with gave two examples of recent safeguarding cases and these had been managed according to policy.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children who was also the safeguarding lead for Harrow. This role included running safeguarding training courses for staff within the practice and the Clinical Commissioning Group (CCG). The lead could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records, for example to alert staff if a child was subject to a child protection plan. These alerts could be hidden if they contained information that may distress a patient. Vulnerable patients were allocated a GP case manager to co-ordinate their care. The practice had reviewed and implemented the Royal College of General Practitioners (RCGP) safeguarding children toolkit to improve documentation and management of safeguarding cases. For example, this included adding a new patient pro-forma to be filled in when patients register for a holistic assessment, a policy to document who has accompanied a child when they attend for an appointment and a section in

the patient notes to prompt clinicians to enquire about any domestic violence concerns. They had also implemented a Red, Amber, Green (RAG) rating system for vulnerable patient alerts to indicate severity of the issues and make this immediately clear when a member of the team was reviewing the patient. The practice maintained a register of all vulnerable patients including their RAG rating.

The practice held quarterly meetings attended by clinicians and health visitors to discuss cases of vulnerable adults and children. They had a system in place to follow up on patients who had missed appointments for childhood immunisations, this included contacting the family by letter or phone call and adding alerts to the notes of all family members so it could be discussed opportunistically when they attended the practice.

There was a chaperone policy, which was displayed in the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. It was unclear if administration staff that may be called to act as a chaperone had received chaperone training as this was not recorded. Patients we spoke with told us they had always been offered the option of a chaperone before any physical examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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. The practice held twice monthly prescription meetings with the local Clinical Care Group (CCG) pharmacist to discuss prescribing data and medicine updates. There was a copy of the local antibiotic policy in each consultation room and we were told the practice's antibiotic prescribing rate was lower than the CCG average.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of Patient Group Directions (PGD) for example, a PGD for Hep A and typhoid. There was evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. For example, the practice offered a nurse led International Normalized Ratio (INR) clinic for monitoring patients taking warfarin and the practice nurses had received appropriate training for this role.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. One of the practice nurses was the lead for infection control and they had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training on infection control specific to their role and received annual updates. 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. The infection control lead carried out infection control audits bi-annually. We saw the results of the most recent infection control audit in January 2015. We saw that action points raised had a named person responsible for implementing the plan, a red/amber/green rating to indicate urgency and a time frame for completion. For example, there was an action for the provision of foot operated bins in clinical areas within three months and a plan to replace carpets in consultation rooms over the next 24 months.

Records confirmed that a Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) risk assessment had been undertaken by an external company in January 2015 and that recommendations had been included in the practice's infection control plan. We saw a microbiological report that showed no legionella had been detected in samples taken from water supplies in January 2015.

Good

Are services safe?

There was a policy for managing biological substances and minimising risk of infection from these. Spillage kits were available in all consulting rooms and staff had been instructed on how to use them when required. The practice used single use equipment only. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Staff were up to date with required occupational health Hepatitis B vaccinations. Personal protective equipment (PPE) including disposable gloves

and coverings were available for staff to use to minimise cross-infection risks. There were disposable curtains in all consultation and treatment rooms which displayed a current date.

An external contractor was responsible for the cleaning of the premises and we were shown a cleaning schedule that detailed the daily, weekly and monthly routine tasks. We saw a signed and a dated cleaning schedule checklist that indicted the areas in the practice that had been cleaned. However during our inspection we observed some areas in the practice to be in a poor state of cleanliness. For example, we found the only patient toilet which included baby changing facilities required cleaning and consumables including toilet paper and hand gel needed replenishing. There was a plastic sanitary bin that was extremely dusty along with a rusty sanitary bin with no indication of purpose or use. There were paper towels available but they were not stored in a protective towel holder.

We observed that hard floor areas on the ground floor were dirty and that some clinical waste receptacles were unclean. We were told members of the nursing team were responsible for cleaning of medical equipment and clinical areas, however there were no clear cleaning regime or records in place to confirm this. All these issues were brought to the immediate attention of the practice management team who after the inspection advised us that a new external cleaning contractor had been appointed and a formalised internal clinical cleaning protocol had been put in place.

The practice had a clinical waste management protocol in place and waste was correctly segregated and disposed of by a professional waste company. However we observed clinical waste bins stored outside of the practice premises awaiting waste collection were not locked and the gate to access the bins was also unlocked. We brought this to the immediate attention of the management team who advised us after the inspection that clinical waste bins had now been safely secured.

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 annually. However we noted that a blood pressure monitor in the Link nurse bag did not display a calibration sticker, which we were told was because it had recently been purchased. We were shown an inventory list of 84 items of medical equipment that had been calibrated in June 2014. All portable electrical equipment was routinely tested. Records we reviewed confirmed portable appliance testing (PAT) had been completed within the last year. There was a contract in place for regular oxygen cylinder replacement.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff including qualification checking, reference request protocols and the vetting and barring scheme. 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).

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. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual checks of the building, environment and equipment. There was a health and safety policy for staff to follow and training certificates demonstrated staff had received training in health and safety. During our inspection it was noted some parts of the premises were in need of refurbishment or repair, for

Good

Are services safe?

example part of the wooden floor in the ground floor corridor needed repair as it posed a trip hazard. We saw that this had been identified by the practice and was included for repair in the next three months as part of the practice's refurbishment renewal programme. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

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). When we asked members of staff, they all knew the location of this 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 (serious allergic reaction), chest pain, breathing difficulties and hypoglycaemia (low blood sugar). All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included influenza pandemic, fuel crisis, loss or disruption to communications or IT, severe weather and loss of utilities such as electricity, heating or water.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills and audited these for improvement. Fire extinguishers at the practice were checked regularly and were in date.

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 (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. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, women's health, dementia and prescribing and the practice nurses supported this work by running long term condition management clinics, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

One of the GP partners was lead for prescribing and told us the practice's antibiotic prescribing rates were lower than the CCG average. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. As part of local enhanced services the practice had achieved the 2% target and had completed integrated care plans for 2.48% of the at risk patient population identified.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral, for example urgent two week referral for suspected cancers. The practice had processes in place to reduce the number of referrals to secondary care. Three of the GPs were trained at fitting pessaries and this helped to reduce referrals to gynaecology. The practice had a process for internal review of referrals prior to them being sent on for secondary service. Once a referral was written it would be sent to the referral group email for all GPs in the practice to review first and offer advice or agree to see the patient themselves if the issue was within their area of interest, with the aim of reducing unnecessary referrals to secondary care.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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 practice showed us eight clinical audits that had been undertaken in the last four years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the practice completed an audit on Non Steroidal Anti-Inflammatory Drug (NSAID - a type of pain killer) prescribing and identified acute one off prescriptions of one particular NSAID as an area for improvement. The results were discussed at a practice clinical meeting to disseminate the guidelines for prescribing NSAIDs and the need to review acute prescriptions. The follow up second cycle audit following clinical staff education on the topic, found acute prescriptions of NSAID medication had reduced. Other examples included audits on screening for Coeliac disease in patients diagnosed with Irritable Bowel Syndrome, medical record keeping and anticoagulation prescribing in patients with atrial fibrillation.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, the practice conducted an audit of patients with atrial fibrillation (an abnormal heart rhythm) to ensure their electronic records contained documentation of their risk of a blood clot and this was linked to QOF data.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in asthma, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, dementia, mental health and the majority of the minimum standards in diabetes and high blood pressure. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines to prompt review of certain medications and offer alternatives before they were prescribed. The practice had a prescribing 'near miss' email group to highlight any potential prescribing issues to the whole clinical team.

The practice had a palliative care register and held regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements, eight had been revalidated and two were awaiting revalidation. (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 interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example family planning certificate for one of the practice nurses. As the practice was an accredited training practice, doctors who were training to be qualified as GPs were offered extended appointments, had access to a senior GP throughout the day for support and were given protected time to attend clinical meetings. We received positive feedback from the trainee we spoke with who told us they felt very much supported by the GPs at the practice.

The practice employed a regular GP locum who also gave positive feedback about their experience of working at the practice. They told us they felt well supported by the practice staff and involved in the team by being encouraged to attend practice training sessions and social events. They told us the locum pack provided to locum GPs working at the practice was good and contained useful information such as the referral pathways, prescribing information and contact numbers.

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, infection control, wound care and family planning. Those with extended roles, for example INR monitoring and management of patients with long-term conditions, were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice manager had worked as part of the administration team previously and had been supported by the practice team to undertake a management course to provide them with the relevant qualifications to become the practice manager.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 services by fax and by post. These were scanned in by administration staff on the day received and any urgent issues were passed on to the duty doctor to action same day. All staff we spoke with understood their roles and felt the system in place worked well. Blood results for review were shared equally amongst the practice's GP's as they could not be sorted back to the specific GP who requested them. The practice had a policy for clinicians requesting

Good

Are services effective?

(for example, treatment is effective)

results to provide clear indications and action plans in patient's notes to ensure continuity and assist interpretation of results by other GPs. Patients who had received blood tests were given a day and time to call the practice to discuss their results with one of the GPs. We were told GPs would often book patients a phone or face-to-face appointment if there were urgent issues to be discussed following the receipt of blood or other diagnostic test results.

The practice held multidisciplinary team meetings bi-monthly to discuss the needs of complex patients, for example frail elderly patients or children on the at risk register. These meetings were attended by district nurses and health visitors and decisions about care planning were documented in a shared care record. The practice also held regular palliative care multi-disciplinary team meetings to discuss patients receiving end of life care.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system to share information in a secure manner with the out-of-hours provider about patients receiving palliative care. Electronic systems were also in place for making referrals, the practice made 50% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of date, place and time for their first outpatient appointment in a hospital). The remainder of referrals to secondary care services were done via referral letters to the appropriate service.

The practice had signed up to the electronic Summary Care Record and patients were given forms to complete if they wished not to be enrolled in the system. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). When new patients registered with the practice they were given patient participation group (PPG) enrolment forms to complete.

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

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice, for example GPs told us of scenarios when they had assessed capacity for patients declining treatment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of a health action plan, which they were involved in agreeing. The practice provided care to patients with learning disabilities living in local specialist care homes. They performed annual review with blood tests for these patients and this required in some situations documentation of capacity and best interest decisions that were made with the support of the local Learning Disabilities Consultant. 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.

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

Health promotion and prevention

The practice had met with the Public health team from the local authority and the CCG to discuss the implications 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 twenty minute health check appointment with a GP to all new patients registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic cervical smears and offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

The practice told us they were not currently offering routine NHS Health checks due to nurse shortages and they had decided to focus on completing integrated care plans for patients at high risk of admission.

The practice had a blood pressure monitoring machine and scales in the waiting area for patients to use themselves to monitor blood pressure and weight. There was a dedicated section within the waiting area where patients could access a variety of health information including a computer for patients to obtain information from the practice website. The practice's patient participation group (PPG) was proactive in promoting the health of the patient population. They ran annual healthy living days for patients to attend and had arranged cardio-pulmonary resuscitation (CPR) courses.

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 had identified patients at risk of admission and achieved the target of completing integrated care plans for 2% of these patients. The practice kept a register of all patients with a learning disability and offered them an annual physical health check including domiciliary health checks for patients living in local specialised care homes. The practice had identified the smoking status of 90% of patients over the age of 16 and signposted them to local pharmacy led smoking cessation services. Similar mechanisms of identifying 'at risk' groups were used for patients who were overweight. The practice told us there was often a long waiting list to see the dietician and they made use of in–house diet sheets and information to assist patients make lifestyle changes.

The practice's performance for cervical smear uptake was 81%, which was in line with the CCG average. There was a policy to offer letter or text message reminders for patients who did not attend for cervical smears. There was also a named nurse responsible for following up patients who did not attend screening. The practice uptake rates for breast and bowel screening for 2014 were 71% and 56% respectively which was at average for the CCG area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The uptake rates for flu vaccinations were in line with the CCG average and the practice offered Saturday and evening flu clinics to enable people who could not attend during normal hours to receive their flu vaccinations. The uptake rate for childhood immunisations was above 95% for the last quarter. The practice ran a personalised follow up service for patients who did not attend childhood immunisation appointments. This involved sending three reminder letters and if these did not elicit a response the practice nurse would establish if another member of staff knew the family well and they would call the family personally to invite them to attend for immunisation. Any concerns were flagged up with the health visitor.

The practice had a section on their website which provided information and advice for patients fasting during Ramadan.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, caring, and respectful towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice staff and that staff were helpful, kind, efficient, gentle and caring. Many of the completed Care Quality Commission (CQC) comment cards we received referred to staff as supportive, respectful, helpful, personable, caring and friendly.

Evidence from the latest GP national patient survey published by NHS England January 2015 showed that patients were satisfied with how they were treated. Eighty-six per cent said that the last GP they saw or spoke to was good at treating them with care and concern and 88% found the receptionists at the surgery helpful. Ninety per cent of patients said they would recommend the surgery to someone new in the area, which was above the Clinical Commissioning Group (CCG) average for the area at 72%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was a room available if patients wanted to discuss something away from the reception area and for breast feeding mothers.

The practice had a chaperone policy and information about chaperoning was displayed in consulting rooms. Patients had the option to see a male or female GP when booking an appointment.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 83% of respondents said the last GP they saw involved them in decisions about their care and 93% said the last GP they saw was good at listening to them. Eighty seven per cent of respondents said the last nurse they saw was good at giving them enough time and 87% said the nurse was good at explaining tests and treatments.

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received. They also told us the GPs gave them enough time and explained results and treatment options well to help them make informed decisions about their care. Patient feedback on CQC comment cards we received reflected this feedback.

Staff told us that a telephone translation service was available for patients who did not speak English as their first language and was used to involve patients in decisions about their health care and to obtain informed consent. Patients requiring translation services were offered double appointments.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. CQC comment cards we received reflected this feedback. Information in the waiting room signposted patients to a number of support groups and organisations, although this information may not be easy to access due to the volume of leaflets on the notice boards.

The practice kept a register of patients who were carers, including those who were foster parents. The practice computer system alerted GPs if a patient was a carer. We saw written information available in the waiting room and on the practice website for carers to raise awareness of support available to them for example, Carers Direct. We saw minutes from a practice meeting were staff had received carer's awareness training provided by a local carers support group.

Procedures were in place for staff to follow in the event of the death of one of their patients. This included informing other agencies and professionals who had been involved in the patient's care, so that any planned appointments, home visits or communication could be terminated in order to prevent any additional distress. Any patient deaths were discussed in the practice weekly team meeting so that staff were all aware when a patient had died.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice had close links with the palliative care nursing

Good

Are services caring?

team and held regular meetings with them. Two of the patients we spoke with had personal experience of end of life care offered by the practice and they both spoke highly of it.

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 patient'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 NHS England Area Team and 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. One of the GPs was on the board of the CCG and therefore any concerns or suggestions from the practice would go through them.

All patients at the practice aged over 75 years had a named GP to co-ordinate their care. GPs had the option to book a follow up with their patients up to one month in advance to allow regular review and continuity of care. The practice used risk stratification tools to identify frail elderly patients at high risk of hospital admission and they had been proactive in developing integrated care plans that included a frailty score for these patients to help manage their care. At the time of our inspection the practice had reached their target to have 290 care plans completed. The practice offered medication review to patients on ten or more medications to attempt to reduce poly pharmacy. Compression bandages and leg Doppler's (arterial circulation check) can be performed in house for patients with chronic leg ulcers.

The practice led a new pilot initiative in the recruitment and training of three practice nurse specialists (GP Link Nurses) working as a shared resource across five local GP practices to improve the care of elderly housebound patients. The link nurse role involved assessment of the care needs of frail elderly patients in their homes, linking with relevant community and social support services to embed action plans formulated as part of the integrated care plan care. The GP link nurses had received training from local respiratory and cardiac specialist nurses and were also involved in long term condition monitoring. They attended weekly meetings at the practice to discuss cases and provide feedback on progress. The practice had received 15 months funding for the scheme from December 2014 and we were told they hoped to continue longer if it was successful.

The practice held nurse-led management clinics for patients with long-term conditions, such as asthma and chronic obstructive pulmonary disease (COPD). There was a weekly GP led diabetes clinic that offered extended 30 minute appointments for new patients. The GP specialist lead for diabetes provided training for practice staff on the condition. All patients with long term conditions were offered annual review with a recall system to invite patients for review during the month of their birthday. The practice used risk stratification tools to identify patients with long term conditions at high risk of hospital admission and had achieved their target of completing integrated care plans for 2% of these patients.

The practice offered a full range of childhood immunisations with uptake rates comparable to the CCG average. The practice nurse had a process to follow up on patients who did not attend immunisation appointments, this included three reminder letters and then a phone call by a member of the practice staff who knew the family well to discuss attendance. Immunisation appointments were offered on Saturday for those patients who could not attend the practice during weekday hours. The practice maintained a list of carers including those who were foster parents to offer additional support if required. The practice ran a baby clinic with the health visitor team for child development monitoring. We were told the practice had just been approved to take part in a Central London paediatric scheme called the 'Sneezy/Wheezy Project' aimed at reducing admissions in children and young adults with asthma. The practice website had an area focusing on health for patients aged 16-25 years that promoted chlamydia screening and gave advice on testing for other sexually transmitted infections.

The practice had systems in place to support the needs of patients whose circumstances may make them vulnerable. Alerts were added to patient notes to make staff aware of any extra needs when reviewing the patient, for example patients with hearing impairment were offered double time appointments if required. The practice maintained a register of patients with learning disabilities and these patients were offered annual health checks that included medication review and blood tests. Patients with learning disabilities were offered appointments earlier in the day to minimise any distress caused by long waiting times. The practice provided care to patients with learning disabilities living in local specialist care homes and made annual domiciliary visits to perform health checks in addition to

Good

Are services responsive to people's needs?

(for example, to feedback?)

home visit review as and when required. We were told the annual review visits were supported by the local Learning Disability Consultant to assist with management of complex health issues.

The practice maintained a list of patients with issues with drug misuse requiring methadone prescriptions. These patients had a named GP to co-ordinate their care. Three of the practice GPs had received specialist training in drug addiction and one of them also worked in a local drug addiction unit. The practice had access to a local drug centre that they could refer patients requiring detoxing to.

The practice told us they had implemented a CCG Dementia pathway and as a result there had been an increase in the number of diagnoses made. The GPs had attended local CCG led training on dementia to improve knowledge and understanding. We were told they would screen opportunistically for memory concerns and refer patients on to the local memory service if required. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health. They engaged with the local community mental health team and a psychologist attended the practice on a weekly basis.

The practice maintained a register of patients receiving end of life care and this information was shared with the out-of-hours provider. Staff had received training in the 'Coordinate my care plan' scheme and we were told of a case where this had recently been implemented. The practice held regular multi-disciplinary team meetings with the palliative care team to discuss the needs of patients receiving end of life care.

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). For example, the blood pressure monitoring machine and scales had been made available in the waiting area for patients to use as result of feedback from the PPG.

Tackling inequity and promoting equality

The practice had access to telephone translation services and patients were offered a double appointment if translation services were required. Several of the GPs were able to speak different languages and could assist in translation if required. Default double appointments were booked for patients who were profoundly deaf and for patients that this was known would be of benefit.

The premises and services had been adapted to meet the needs of patient with disabilities, for example there was ramp access into the reception area. However, we noted there was no automated door available for patients in wheelchairs. The reception desk had a drop down section to make it accessible for wheelchair users. There were two disabled parking spaces in the practice car park.

We saw that space in the waiting area was limited and if full may not accommodate patients with wheelchairs and prams. There was one patient toilet available that was accessible for disabled patients and contained baby changing facilities.

Access to the service

The practice was open from 8.00am to 7.30pm Monday and Tuesday, 7.30am to 8.00pm on Wednesday and 8.00am to 6.30pm Thursday and Friday. Pre-bookable appointments with the practice nurse were available at the branch surgery each Saturday from 8am to 11am and from 1.00pm to 3.30pm. Appointments could be booked online and repeat prescriptions could be requested through the practice website. There was the option to request telephone consultations on the same day for problems that could be resolved over the phone for patients who could not attend the practice. Text message reminders were used for appointments.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, they were directed to 111 NHS advice line. Information on the out-of-hours service contracted by the practice was not provided to patients.

Longer appointments were also available for patients who needed them, for example those with long term conditions, hearing impairment or translation requirements. Home

Good

Are services responsive to people's needs?

(for example, to feedback?)

visits were available for patients unable to attend the surgery due to immobility or illness. The GPs also provided domiciliary care to patients with learning disabilities living in local specialist care homes.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Feedback from the National GP patient survey published in January 2015 showed patients were satisfied with the appointment system with 80% of respondents describing their experience of making an appointment as good and 82% of respondents stating they found it easy to get through on the phone. These were above the average satisfaction scores for the CCG area. Some patients we spoke with felt the wait to be seen from their appointment time could be long. This was reflected in the National GP survey results with only 51% of respondents reporting a wait of fifteen minutes or less from their appointment time.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the practice information leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 39 complaints received in the last 12 months and found the majority had been managed according to the complaints procedure in a timely way. We saw learning points had been identified for each complaint and any planned changes to service as a result of the complaint had been actioned. For example, a complaint had been received about a problem with accessing an urgent same day appointment and as a result the reception staff were given update training on the appointment booking system to ensure they all fully understood the procedure. The practice held an annual complaints meeting to review all complaints and detect themes or trends.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide their patients with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. They aimed to achieve this by developing and maintaining a practice responsive to people's needs and expectations and which reflects whenever possible the latest advances in primary health care. This vision included five core values; Patients first and foremost; Today's work today; Safeguarding is everyone's business; Flexibility for patients and staff; Education for all. The vision and practice values were part of the practice's strategy and business plan.

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 six of these policies and procedures and found they were all up to date. The practice had completed an online Department of Health information governance assessment which showed they were performing satisfactorily with regards information governance management, data protection and information security.

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 one of the GP partners was the lead for safeguarding. Staff we spoke 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 discussed at clinical team meetings and action plans were produced to maintain or improve outcomes.

The practice had in-house email peer review system to identify those that could be managed by other staff in the practice and ensure all referrals made were appropriate to improve the referral process. 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. For example, a recent completed audit on screening for Coeliac disease in patients with irritable bowel syndrome found this was not being offered routinely as per best practice guidelines and following staff education rates of screening had improved.

The practice held weekly management issues with the practice manager and members of the administration and reception staff to discuss governance issues. Minutes confirmed governance issues were discussed and action plans recorded.

Leadership, openness and transparency

We saw from minutes that practice team meetings were held monthly with weekly clinical team meetings and management meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice manager had been supported by the practice team to gain additional qualifications and move up from their previous role as one of the practice administration team. There were regular social events that all staff including regular locum staff were invited to attend.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, reference requesting, vetting and barring scheme and induction policy, which were in place to support staff. An electronic staff handbook was available to all staff, on any computer within the practice. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the National GP patient survey, Patient Participation Group (PPG) led patient survey, Friends and Family Test, comments and complaints. Results from the PPG led patient survey in 2014 found some patients reported long waiting times for telephone calls to be answered and as a result the practice provided additional training for reception staff including prioritising and managing telephone calls. They also had a longer aim to recruit additional reception staff to reduce telephone waiting times.

The practice had a very active and enthusiastic PPG named the Ridgeway Surgery Patient Group which had steadily increased in size. The PPG included representatives from various population groups; including patients aged over 75

Are services well-led?

Good

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

years, working age groups, patients from different ethnic backgrounds and young adults. The PPG met every quarter, survey results and analysis and action plans were published on the practice website. New patients joining the practice were given the choice to opt in or out of receiving PPG information and were given an information leaflet along with joining form to explain the role of the PPG.

The PPG produced a quarterly newsletter that was distributed to all members and was also available in the waiting area and on the practice website. The newsletter provided an update on activity, staffing news, changes to services such as introduction of named GP for over 75 year olds, patient stories, support organisation contact details, health or condition information and medical news.

The PPG ran regular educational courses and events for patients, including talks by the practice GPs and external guest speakers on specialist topics. These included for example 'living with arthritis', 'diabetes and how to avoid it', the learning disability programme and dementia education. One recent talk presented by an external consultant psychiatrist discussed 'what might psychotherapy offer to patients with physical symptoms'. They had organised basic life support training for patients for example a 'Heart start' course run by trained London Ambulance Service First Responders was held at the practice twice a year and 83 people had been trained since 2012. They also ran annual healthy living days aimed at promoting health education and sharing health information. We saw that feedback about the courses and events held were gathered from patients and presented on the practice website. We were told that the PPG was in the process of registering as a charity to receive donations to support their activity within the community.

The practice gathered feedback from staff through regular team meetings and annual appraisals. 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.

The practice had a whistleblowing policy, which was available to all staff in the staff handbook and electronically on any computer within the practice.

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 reviewed staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and funding was available if required, for example one of the practice nurses had been supported to complete their family planning certificate.

The practice was a GP training practice and employed a GP registrar. They told us they felt supported by the practice and always had a named senior supervisor available to discuss cases or concerns. They had the opportunity to discuss learning topics in regular tutorials with supervisors and were given protected time to attend clinical meetings and teaching sessions.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, an incident with emergency referral to hospital when a patient had to attend the hospital twice was discussed at the clinical team meeting and as a result a letter highlighting the issues was sent by the practice to the hospital management team to prevent them occurring in the future.