Stanhope Mews 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 Stanhope Mews Surgery on 16 June 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 people with long-term conditions, families, children and young people, people whose circumstances may make them vulnerable, people experiencing poor mental health (including people with dementia), working age people (including those recently retired and students) and for the care of older people.

Our key findings 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, including those relating to recruitment checks.
- 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 they found it easy to access the GPs 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.
- 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.

We saw areas of outstanding practice:

Summary of findings

- Proactive care of older patients; The practice had 393 care plans in place and worked closely with other health care professionals to ensure the needs of older patients were met.
- The practice had a 'surgery pod' which was accessible for patients to use at the practice without needing an appointment with a GP or nurse. (The 'surgery pod' is a touchscreen computer that enables patients without clinical supervision, to measure their own vital signs for example, blood pressure and pulse rate, or basic information including weight and height).

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

The provider should:

- Ensure prescription pads are stored securely.
- Review procedures for the prescribing of anti-malarial medicines.

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. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

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. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received 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. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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 however there was a wait to see a named GP. Urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information

Summary of findings

about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures 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, which it acted on. The patient participation group (PPG) actively engaged with the practice. 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. The practice had a high number of older people with 14% of the patient list over 75 years old and 6% of these, over 90 years old. To meet their needs the practice proactively worked with district nurses and the palliative care team to case manage and care plan these patients. The practice also worked with a primary care navigator who acted as a care co-ordinator for older patients to help with their non-medical needs. The practices' QOF performance in 2014 for palliative care indicators was 100% with a clinical prevalence above both CCG and national averages.

The practice identified older patients at high risk of admission to hospital and developed care plans during appointments with the patient. As part of this service patients over 70 years of age were invited into the practice or visited at home for annual health checks which included weight and blood pressure checks, hearing and memory tests and screening for depression and anxiety. At the time of our inspection there were 393 care plans in place for older patients. Older patients were on the Co-ordinate My Care (CMC) register to ensure all relevant health care professionals could access the care plans. Older patients were also treated as a priority in the practices' triage system.

The practice had links with the Royal Hospital Chelsea and a named GP spent one day a week there providing care and treatment for the resident Chelsea Pensioners.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. A GP and nurse had completed a programme to deliver advance care to diabetic patients and dedicated diabetic clinics were planned to be offered in the near future. The practice provided an in-house anticoagulation service for those patients on warfarin and provided in-house electrocardiogram (ECG) and ambulatory blood pressure monitoring services.

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Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided emergency walk-in clinics every morning from 9-11am, and every afternoon from 3-5pm to meet the needs of this population group. Reception staff identified young children and babies booked into the emergency clinics so that the GPs prioritised them. The practice worked closely with young families to ensure babies and children were immunised in a timely way. The health visitor attached to the practice ran in-house child health and well-baby clinics on Wednesday afternoons to support the needs of families with young children. The practice also ran regular family planning clinics providing patients which included gynaecological services, emergency contraceptive advice and maternity care. Opportunistic chlamydia screening was provided for those patients aged 17-25.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice had an automated health POD which was available at any time for patients who wished to check their blood pressure, weight, height and other assessments without the need for an appointment. The practice ran early morning and evening clinics to cater for working age patients and students as well as early morning walk-in clinics. The practice recently went live on Twitter as a means to communicate relevant health-related bulletins and updates, and were about to go live with Skype appointments in late June 2015.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a learning disability register with nine patients on it and all had received an annual health check in the previous year. Most staff had received safeguarding adults training. The safeguarding lead GP attended local safeguarding meetings regularly and safeguarding was a standing item on the practice's weekly meeting agenda. The practice had a primary care navigator who organised befriending and social help amongst other services for vulnerable patients. Where the primary care navigator was unable to help herself,

Summary of findings

patients were signposted to appropriate services. The GPs and nurses screened patients opportunistically for health problems associated with alcohol and drugs and referred patients to the community drug and alcohol clinic when necessary.

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). Longer appointments are offered to this patient group. Robust systems were in place to ensure patients commenced on anti-depressant medicines or with a new diagnosis of depression were followed up in a timely manner. The practice had an in-house counsellor who offered both NHS and private appointments for patients in this population group. The primary care navigator had links with specialist dementia nurses. The practice participated in a mental health initiative which invited patients on the mental health register in for annual health checks. Patients on long term anti-psychotic medicines were proactively contacted for regular reviews and blood tests and if they could not be contacted or did not attend, the practice alerted the patient's community psychiatric nurse. GPs at the practice also attended annual meetings with consultant psychiatrists from Chelsea and Westminster Hospital to jointly review patients on the register and update treatment plans where necessary. The practice had a register of mental health patients and out of 96 patients on the register 94 had a care plan in place. Older patients were proactively screened for dementia.

Summary of findings

What people who use the service say

We spoke with 14 people who used the service. We reviewed 15 completed comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the national GP patient survey 2015 where 93 patients out of 421 responded to the survey (22% completion rate), the practice's annual satisfaction survey and the NHS friends and family test. Feedback we received from all these sources was positive. 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. Patients said the practice was very responsive to their needs and they were satisfied with the care and treatment they received.

Areas for improvement

Action the service SHOULD take to improve

- Ensure prescription pads are stored securely.
- Review procedures for the prescribing of anti-malarial medicines.

Outstanding practice

- Proactive care of older patients; The practice had 393 care plans in place and worked closely with other health care professionals to ensure the needs of older patients were met.
- The practice had a 'surgery pod' which was accessible for patients to use at the practice without needing an appointment with a GP or nurse. (The 'surgery pod' is a touchscreen computer that enables patients without clinical supervision, to measure their own vital signs for example, blood pressure and pulse rate, or basic information including weight and height).

Stanhope Mews 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, a practice nurse and an expert by experience.

Background to Stanhope Mews Surgery

Stanhope Mews Surgery is situated at 7 Stanhope Mews West, London, SW7 5RB. The practice provides primary medical services through a Personal Medical Services (PMS) contract to approximately 9,219 patients in West London (PMS is one of the three contracting routes that have been made available to enable commissioning of primary medical services). The practice is part of the NHS West London Clinical Commissioning Group (CCG) which comprises 51 GP practices. The practice population is diverse and there is a higher than national average number of patients between 25 and 44 years of age. The practice list is also one of the highest in the London borough of Kensington and Chelsea in terms of its proportion of elderly patients with over 14% of patients over 75 years old, 83 of which are over 90 years old. The practice also has a higher than national average number of children under four years of age. Life expectancy is 81 years for males and 85 years for females which is above the national average. The local area is the third least deprived in the West London CCG (people living in more deprived areas tend to have greater need for health services).

The practice team consists of three GP partners (two male and one female) and a salaried female GP. There are two practice nurses, health care assistant, practice manager and assistant, administrator, secretary and six receptionists. There is also a health visitor and primary care navigator based at the practice. The practice is a GP training practice and has two GP Registrars in training. The practice is open between 08:00 and 18:00 Mondays and Thursdays, 07:00 and 20:00 Tuesdays, 08:00 and 20:00 Wednesdays, and 07:00 to 18:00 Fridays. Appointments could be made Monday to Friday 08:30 to 13:00 and 14:00 to 18:00 by phone or throughout the practice opening hours in person. An online appointment system was also in place. The practice has opted out of providing out-of-hours services to their own patients and directs patients to the NHS 111 service and a local NHS Walk-in Centre.

The practice offers a wide range of services/clinics including family planning, maternity care, baby and pre-school checks, child health and well-baby clinic, travel immunisations, flu clinics, minor surgical procedures, new patient health checks, INR clinics and blood tests.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

Why we carried out this inspection

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, and to look at the overall quality of the service.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced comprehensive inspection on 16 June 2015. During our visit we spoke with a range of staff including two GPs, two nurses, health care assistant, primary care navigator, practice manager three reception/administration staff. We spoke with 15 patients who used the service, ten of whom were involved with the Patient Participation Group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 14 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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 one significant event we reviewed involved a patient who was sent in error a follow up letter following a smear test when the test results were normal. The practice took action to ensure staff received additional training on the computer system.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 14 significant events that had occurred over the last year and saw this system was followed appropriately. Significant events were a standing item on the weekly meeting agenda. 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 incident forms available on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked 14 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, learning from a significant event involving a mis-diagnosed appendicitis was shared in a weekly clinical learning session and a consultant surgeon from a local hospital was invited to provide an educational session on this topic. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated via email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in weekly meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example a recent alert received was to warn practices to the potential risks to children from blind cords. This was shared in a meeting and action was taken to ensure blind cords were removed from windows where necessary.

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 most staff had received relevant role specific training on safeguarding. Clinical staff were trained to Level 3 in child protection and non-clinical staff to Level 1. Staff were also trained in safeguarding vulnerable adults. However, we did find that two reception staff had yet to receive safeguarding training although it had been scheduled in. 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. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. 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. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Good

Are services safe?

There were chaperone notices, which were visible in the practice. (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). The health care assistant and reception staff undertaking chaperone duties had been trained to be a chaperone. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice. However they were not always kept securely as we found blank prescription forms in an unlocked cabinet potentially accessible to the public.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs and they were all in date. The healthcare assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that the nurses and healthcare assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a Patient Specific Direction (PSD) from the prescriber.

The nurses administered anti-malarial medicine using a PGD. This medicine was dispensed by the practice by private prescription. Patients received this medicine as calculated by the nurse and the computer system generated a prescription signed by the GP. However, we found the GPs did not always read the consultation prior to signing the prescription and therefore could not be assured that the medicine was prescribed safely. We also found the batch numbers of the medicine given were not recorded in the patient notes. We raised these issues with a GP partner on the day of our inspection who told us that anti-malarial medicine prescribing would be urgently reviewed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

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

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 and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who 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 about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an

audit in the previous year and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date was within the last year. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

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, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice had carried out a health and safety risk assessment where each risk was rated and action points to mitigate risk recorded.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage foreseeable emergencies. Records showed that all staff had received training in basic life support annually. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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 power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services safe?

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 although they had not practised regular 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 (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to appropriate staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required and in a timely way.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, 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. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this had occurred.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

The practice showed us five clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit was carried out to check patients prescribed a particular statin was in line with NICE guidance. The initial audit identified 48 patients on the statin all of whom were prescribed the medicine in line with NICE guidance. A re-audit identified 46 patients on the statin all of whom were prescribed the medicine in line with NICE guidance. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. We also saw an audit carried out following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding an antibiotic used to treat urinary tract infections which was contraindicated for patients with poor renal function. Out of 26 patients prescribed the antibiotic, eight were contraindicated and as a consequence their medicine was reviewed.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. It achieved 87.9% of the total QOF target in 2014, which was below the national average of 93.5%. Results for clinical indicators were mixed. Specific examples to demonstrate this included;

- Performance for diabetes QOF indicators was 92.4% which was above the national average of 90.1%.
- Performance for hypertension QOF indicators was 35.3% which was below the national average of 88.4%.
- Performance for asthma QOF indicators was 100% which was above the national average of 87.2%.

Good

Are services effective?

(for example, treatment is effective)

- Performance for dementia indicators was 76.9% which was below the national average of 93.4%.

In 2015 the practice had increased its QOF performance achieving 93.7% overall.

The practice's prescribing rates were also similar to national figures for all prescribing indicators. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked 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. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice compared their clinical activities with that of other local practices and findings were used to improve outcomes for patients. The practice on a monthly basis reviewed data provided by the local CCG to compare their practice with other GP practices in the CCG area. This included benchmarking of audit results, for example comparing prescribing patterns with neighbouring GP practices in order to improve patient outcomes.

Referral management meetings were held twice weekly at the practice to review referrals made by the GPs to other services. Referrals made by each GP were reviewed and if necessary re-directed to more appropriate services. For example re-directing referrals made to secondary care to alternative community services more suited to a patient's needs. These meetings also provided the opportunity for the clinical team to learn about local services that could be accessed in the community.

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. We noted a good skill mix among the doctors having special interests in a number of areas including minor surgery, diabetes and family planning. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for 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. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, coronary heart disease and cancer, were also able to demonstrate that they had appropriate training to fulfil these roles.

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

Working with colleagues and other services

The practice worked with other service providers to meet 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 service electronically, by fax and by post. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. 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.

Emergency hospital admission rates for the practice were similar to expected when compared to the national average. The practice was commissioned for the

Good

Are services effective?

(for example, treatment is effective)

unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had completed care plans for 2% of the at risk population as recommended by the enhanced service.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long-term conditions, people from vulnerable groups and those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses, the mental health team and the primary care navigator.

Information sharing

The practice used an electronic system to communicate with other providers. For example, 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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The staff we spoke with 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. For some specific scenarios where capacity to make decisions was an issue for a patient, for example patients with a learning disability, the GPs involved families and carers in the decision making process.

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 and had a section stating the patient's preferences for treatment and decisions. 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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 discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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 used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were 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. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 2,802 patients in this age group were offered health checks in the previous year, of which 7.8% of patients took up the offer.

The practice had a 'surgery pod' which was accessible for patients to use at the practice without needing an appointment with a GP or nurse. (The 'surgery pod' is a touchscreen computer that enables patients without

Good

Are services effective?

(for example, treatment is effective)

clinical supervision, to measure their own vital signs for example, blood pressure and pulse rate, or basic information including weight and height). The pod was configured to the practices' electronic patient record system which enabled information to be automatically recorded into the patient's medical record. An alert was built into the system to warn if vital signs fell outside the normal range and that required urgent review by the practice nurse or GP.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had offered smoking cessation advice to 1,096 patients in the previous 12 months of which 1% had successfully stopped smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. For example the practice had an obesity register and offered obesity services through referral to a dietician. The practice also offered HIV testing to patients.

The practice's performance for the cervical screening programme was 70%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for flu vaccination rates for the over 65s was 69%, at risk groups 59%, pregnant women 37% and childhood immunisation rates 70%. Comparators to the CCG and national averages for this data were not available.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015, the practices' annual general practice assessment questionnaire (GPAQ) last completed in December 2014 and the NHS friends and family test.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 80% of respondents would recommend the practice compared to the national average of 78%. Figures from the Friends and Family test showed a consistently high percentage (between 94 and 97% each month) would either be highly likely to or likely to recommend the practice. The practice received mixed responses from the national patient survey for its satisfaction scores on consultations with doctors and nurses. For example;

- 90% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 83% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 82% said the nurse was good at listening to them compared to the CCG average of 86% and national average of 91%.
- 78% said the nurse gave them enough time compared to the CCG average of 87% and national average of 92%.
- 88% said they had confidence and trust in the last nurse they saw compared to the CCG average of 94% and national average of 97%.

However, results from the latest GPAQ showed the practice scored positively for its satisfaction scores on consultations with doctors and nurses and achieved above the GPAQ benchmark figures.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 12 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We also spoke with 15 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a separate room near to the reception desk if patients preferred to talk privately, and there was a sign to that effect displayed. The results from the national patient survey showed that 79% of respondents found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

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 they would investigate these 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.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patient responses were in line with or above the national averages in relation to questions about their involvement in planning and making decisions about their care and treatment. For example;

Good

Are services caring?

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%.

Results from the latest GPAQ showed the practice scored positively for its satisfaction scores on similar questions and achieved above the GPAQ benchmark figures.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt 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 the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed a mixed response in terms of support patients received to cope emotionally with care and treatment, for example;

- 86% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 83% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

However, results from the latest GPAQ showed the practice scored positively for its satisfaction scores on similar questions and achieved above the GPAQ benchmark figures. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with the GPAQ information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also 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 shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice has a policy to call patients who had recently been discharged from hospital to check up on them. Patients we spoke with who had received a call after a stay in hospital said it was much appreciated.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer support. Patients we spoke with who had experienced a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice identified and supported carers opportunistically and there was a system in place to highlight carers on patients' medical records. Carer information was available in the practice.

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. For example, the practice participated in the unplanned admissions enhanced service. As part of this service patients over 70 years of age were invited into the practice or visited at home for annual health checks which included weight and blood pressure checks, hearing and memory tests and screening for depression and anxiety.

The practice participated in a mental health initiative which invited patients on the mental health register for annual health checks. Patients on long term anti-psychotic medicines were proactively contacted for regular reviews and blood tests, and if they could not be contacted or did not attend, the practice alerted the patient's community psychiatric nurse for follow up. GPs at the practice also attended annual meetings with consultant psychiatrists from Chelsea and Westminster Hospital to jointly review patients on the register and update treatment plans where necessary.

There was a primary care navigator (PCN) based at the practice three days a week and worked alongside the practice team. The PCN acted as a care coordinator for older vulnerable patients, and those with mental health and other complex needs. The PCN supported patients to access a wide range of health, social care and other community services. Access to the PCN was through referral by the GPs and the PCN attended monthly multi-disciplinary team meetings to be involved in planning care for patients with complex needs.

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 population in the local area. This information was used to help focus services offered by the practice.

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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, in collaboration with the CCG the practice had signed up to the local CCG 'Whole Systems Pilot' with an aim of delivering integrated care to older patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, longer opening hours, improved customer service at reception and a streamlined online prescription service.

Tackling inequity and promoting equality

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

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were on three levels with lift access. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of 'no fixed abode' but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor and there was good continuity of care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the year and that equality and diversity was regularly discussed at staff appraisals and team meetings.

Access to the service

The surgery was open from 08:00 to 18:00 Mondays and Thursdays, 07:00 to 20:00 Tuesdays, 08:00 to 20:00 Wednesdays, and 07:00 to 18:00 Fridays. Appointments could be made Monday to Friday 08:30 to 13:00 and 14:00 to 18:00 by phone or throughout the practice opening hours in person. The practice also provided walk-in surgeries from 07:00 to 07:45 twice a week to meet the needs of working age patients. There were also walk-in emergency appointments available twice a day for two hour periods with a designated GP and a nurse triage system in place. Appointments could be made in person, by phone or via the practice website. The practice recently went live on Twitter as a means to communicate relevant health-related bulletins and updates, and were about to go live with Skype appointments in late June 2015. Three bookable telephone consultations were available daily for patients with minor ailments The practice website could be used for a number of patient based services including online registration for new patients, ordering prescriptions, accessing educational resources and email communication with clinical staff for non-urgent matters.

Comprehensive information was available to patients about appointments on the practice website and in the patient leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the patient leaflet, practice website and posters in the waiting areas.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one and patients were instructed to call the practice before 10:30 to book a visit.

The patient survey information we reviewed showed mixed responses to questions about access to appointments. For example:

- 73% were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 58% with a preferred GP usually got to see or speak to that GP compared to the CCG average of 65% and national average of 60%.
- 78% described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 79% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.
- 75% said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Waiting times for routine appointments to see a named GP was up to two or three weeks which some patients said was a long time to wait.

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. 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 which included a leaflet about the complaints procedure at reception, posters in the waiting areas and information 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at 14 complaints received in the last year and found they were satisfactorily handled and dealt with in a timely way.

We saw evidence that learning from complaints was shared in team meetings. In addition, the practice held annual complaints meetings to review all the complaints that had been received and make sure all possible lessons had been learnt, and to detect any themes or trends. There were no common themes in the complaints we reviewed.

The practice had a patient liaison officer whose role was to deal with patients concerns and/or issues. The staff member could be contacted by direct line or an appointment could be booked with them. Patients reported that this service was very useful.

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 deliver high quality care and promote good outcomes for patients. The practice also had a motto; "Helping others to help themselves" which was included in the practice handbook and on the practice website.

We spoke with eight members of staff and they all knew and understood the vision and knew what their responsibilities were in relation to it and said they had been involved in its development. Staff were aware of the practice motto and said they carried out their job roles with the motto in mind. The practice was an outward facing practice, engaging fully with the CCG and the development of the local GP federation. The practice was also a pilot practice for the local CCG 'Whole Systems Pilot' in the current year with an aim of delivering integrated care to older patients.

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 ten of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All the 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 and a lead GP for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). 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 areas for improvement identified.

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. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, a fire risk assessment and risk assessments for general health and safety had been carried out. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held regularly. For example, whole staff meetings were held quarterly, partners and clinical meetings weekly and

Are services well-led?

Good

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

reception/administration meetings bimonthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team social events were held regularly. The majority of staff said they felt respected, valued and supported, particularly by the partners in the practice. However one staff member we spoke with said they could not attend staff meetings as they were held outside their working hours and the staff member felt they could be more supported in their job role.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups; including working age and older patients. The PPG had carried out quarterly surveys and met every three months. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with nine members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). Members of the PPG told us that the practice was very proactive in getting patients to participate in the survey which included displaying forms at reception desk and the GPs handing out forms during consultations.

The practice had also gathered feedback from staff through appraisal. 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 five 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 been a GP training practice for the past ten years with strong links to education. The practice had two full time GP Registrars and also regularly hosted medical students on attachment from Kings and Imperial colleges.

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, learning from a significant event involving a mis-diagnosed appendicitis was shared in a weekly clinical learning session and a consultant surgeon from a local hospital was invited to provide an educational session on this topic.