Chiddingfold Surgery

Quality Report

Chiddingfold Surgery
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Chiddingfold Surgery is located in purpose built premises in a semi-rural location. It provides services to just over 4,500 registered patients. The practice dispenses prescriptions to approximately half of its patients.

We carried out a comprehensive inspection on 7 October 2014. We visited the practice location at Ridgley Road, Chiddingfold, Godalming, Surrey, GU8 4QP. Chiddingfold Surgery also operates a branch surgery at Dunsfold Surgery, 20 Griggs Meadow, Dunsfold, Surrey, GU8 4ND. We did not visit the branch surgery as part of our inspection.

We have rated the practice as outstanding. The inspection team spoke with staff and patients and reviewed policies and procedures implemented throughout the practice. Processes and procedures were in place to ensure the safety of patients and staff. The practice was responsive to the needs of the local population and engaged effectively with other services. There was a culture of openness, transparency, continual learning and improvement within the practice. The practice was committed to providing high quality patient care and provided good support and training to staff to facilitate this.

Our key findings were as follows:

- Thorough processes were in place to ensure safe dispensing of medicines to patients.
- Comprehensive assessment of risk ensured the safety of patients and staff.
- Detailed care planning and shared care protocols were in place to ensure the services met the needs of different population groups.
- The practice took a proactive approach to meeting the needs of different groups of patients and used innovative methods to engage with those in vulnerable circumstances.
- Patient feedback showed that patients felt they were involved in making decisions about their care and were treated with kindness and respect.
- Staff were well supported and continuous learning and improvement was encouraged

Summary of findings

We saw several areas of outstanding practice including:

- Highly effective anticipatory care planning for patients with long term conditions.
- Innovative approaches to enable patients in vulnerable groups to access care services.
- The practice took a proactive approach to managing patient admissions to and discharge from hospital.

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

The provider should:

- Improve the level of participation in the patient participation group to ensure the group reflects the practice population.

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 safe. The practice had demonstrated it was safe over time. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety was highly valued. An open and transparent culture meant that all opportunities for learning from internal and external incidents were maximised to support improvement. Dispensing processes were robust and well monitored. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep patients safe. Equipment was available for use in medical emergencies. There were systems to protect patients from the risk of abuse.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patient needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had completed appraisals and personal development plans for all staff. There was extensive evidence of multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). The practice had reviewed the needs of their local population and engaged with the NHS England local area team (LAT) and clinical commissioning

Summary of findings

group (CCG) to secure service improvements where these had been identified. There was a proactive approach to understanding the needs of different groups of patients. Innovative methods had been adopted to encourage patients from vulnerable groups to access care services.

Patients reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their individual responsibilities in relation to this. There was a clear leadership structure and staff felt well supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were robust systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had a small but active patient participation group (PPG). 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

Outstanding 

The practice is rated as outstanding for the care of older patients. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in end of life care.

Patient alerts, raised via the practice computer system and a 'special awareness' whiteboard within the administration area, were used by all GPs within the practice in response to individual patient needs. For example, longer appointments were made available to frail or elderly patients who required extra time to enter the consulting room or undress for examination.

A range of clinics and health promotion services were available to support older patients. For example, diabetic reviews, blood pressure monitoring and dementia screening. Older patients with long term conditions had care plans and these were reviewed at regular intervals. Multidisciplinary meetings took place monthly to discuss at risk patients and those needing palliative care. There was good communication between the practice and other services including the community matron, social services and support organisations for carers. The practice had a safeguarding lead for vulnerable adults. The practice monitored daily hospital discharges and accident and emergency admissions to ensure that patients could be contacted and their care reviewed. The practice was proactive at recognising patients who were at risk of dementia and were using questionnaires to aid screening.

The practice worked closely with one local nursing home and a residential home, to ensure patients received consistent care from a named GP. The GPs worked closely with the nursing homes to improve the service provided. For example, they were developing a future planning document for nursing home patients to ensure their best interests and wishes were respected.

People with long term conditions

Good 

The practice is rated as good for the population group of patients with long term conditions. The practice effectively supported patients with long term conditions to manage their health, care and treatment. All patients had a named GP and this was particularly welcomed by patients with long term conditions to facilitate

continuity of care. Patients with long term conditions and their carers were provided with longer appointments and prioritised for access to appointments via the practice computer system and a 'special awareness' whiteboard located in the administration area.

The practice monitored the prevalence of long term conditions across the practice population in line with best evidence based practice. The practice achieved 98.5% of the maximum Quality and Outcomes Framework (QOF) points for 2013/14, in the clinical domain. The practice nurses were trained and experienced in providing diabetes and respiratory care. This ensured patients with these long term conditions were regularly reviewed and supported to manage their conditions. Regular searches were carried out of the registers of patients with long term conditions. These identified patients who had not attended for regular reviews and prompted the sending of recall appointments.

GPs followed relevant guidelines from the National Institute for Health and Care Excellence (NICE) and the Medicines and Healthcare Products Regulatory Agency (MHRA) for long term conditions management. For example, we saw the practice had recently responded to MHRA guidance relating to the prescribing of medicines to treat epilepsy by brand only. The practice had identified affected patients and all GPs had been informed of the changes required. Prescribing to these patients had been re-audited following a three month period to ensure guidance had been followed.

The practice routinely collected information about care and treatment outcomes for patients with long term conditions. For example, patients prescribed disease modifying anti-arthritic medicines were monitored by the practice through a shared care protocol with secondary care services. The practice held a register of these patients who were recalled for blood testing when required. An administrator within the practice managed this process with the patient's GP reviewing the blood results within 24 hours of receipt. The process was audited by the GP prescribing lead partner on a three monthly basis.

Enhanced anticipatory care plans had been put in place for patients at high risk of hospital admission or using out-of-hours services. We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission, end of life care and a 'ceiling' (an upper limit) of care agreed by the patient.

Summary of findings

Care plans were given to patients to ensure their full involvement and to facilitate sharing of information with other services, such as out-of-hours services. We saw that care plans had been reviewed every three months or more frequently as required.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the population group of families, children and young people. The practice had developed a range of initiatives to support the needs of families, children and young people.

These included weekly antenatal clinics and childhood immunisations. Child immunisation clinics were routinely supported by a designated administrator. This enabled the nurse to concentrate fully on speaking with the parent and child and administration of the vaccine. The practice offered contraceptive implants and coil fitting. The practice supported and promoted the national chlamydia screening programme. Ante-natal care and screening was offered according to current local guidelines. Practice staff had received safeguarding training relevant to their role, and safeguarding policies and procedures were readily available to staff. All staff were aware of the practice child safeguarding lead and how to respond if they suspected abuse. The practice ensured that children needing emergency appointments would be seen on the day. There was clear communication between the practice and other services including midwives, health visitors and support organisations. Monthly meetings between the practice and the health visitor enabled them to share concerns when they arose.

The practice had developed ways of sharing information with local services. One GP partner provided an annual sex education talk within a local primary school. Another GP partner gave a talk each term to young patients at a local special school about confidentiality, safeguarding and accessing the services of GPs and nurses within the practice.

The practice had set up a social media page as a way of engaging with younger patients.

Working age people (including those recently retired and students)

Good ●

The practice is rated as good for the population group of the working-age people (including those recently retired and students). Patients could book appointments either by telephoning, in person or on line via the practices website. This ensured patients were able to book appointments with the practice at times and in ways that

were convenient to them. The practice had introduced a weekly late evening and early morning surgery for routine appointments to accommodate the need of working age people. Occasional Saturday morning flu immunisation clinics had also been made available.

Patients were able to use the on-line repeat prescription service. Patients were able to see the GP of their choice and could request to see a GP of the same gender. The practice nurse provided travel advice and immunisation. Relevant health and screening clinics were available to detect and prevent illness and promote general health and wellbeing.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable.

The practice supported patients with a learning disability who were registered with the practice. There was a lead GP for patients with learning disabilities and patients received annual health checks and regular reviews. The practice provided support to a register of nine patients with learning disabilities within a local special school, providing enhanced services under shared care protocols.

The practice had identified innovative ways of promoting health services to hard to reach groups. During a recent measles outbreak, one GP partner visited a local traveller community and spoke with them directly about the benefits of MMR vaccination and the support available to them in accessing care services via the practice.

Translation services were available for patients who did not use English as a first language. The practice provided a hearing loop to assist patients who were hard of hearing. The practice had good access for those with limited mobility or who used wheelchairs. The practice supported patients who registered as a carer. The practice was aware of and promoted other services that could provide support for this population group.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). There were policies and procedures for safeguarding children and vulnerable adults and appropriate systems in place to respond to any concerns. GPs used a screening tool to assist them in making preliminary diagnoses of dementia. The practice offered a range of services to patients experiencing mental health problems. Patients were referred to counselling services when appropriate. The practice provided accommodation for use by private and NHS counselling services to support patients with poor mental health.

Summary of findings

GPs within the practice raised alerts to highlight individual patients with poor mental health who may require longer appointments to talk with their GP or who may not be able to express their need for a timely appointment. A range of leaflets detailing support groups was available. The practice held regular multidisciplinary meetings which included the community psychiatric nurse**.** Patients with severe mental health needs had care plans and new cases had rapid access to community mental health teams.

Summary of findings

What people who use the service say

We spoke with four patients during the inspection and we received eight comment cards from patients who had visited the practice in the previous two weeks. We also spoke to a representative of the patient participation group and reviewed feedback information from 22 other patients registered with the practice.

All the patients we spoke with were extremely positive about the service they received. They told us they had no problems contacting the practice and appointments were readily available. They told us that staff were professional and treated them with respect.

Comments received through the patient participation group and the comments cards were all extremely positive about the service patients received. Comments received included patients feeling listened to, supported and treated with dignity and respect.

We viewed the results for the National GP Survey July 2014. 114 patients had responded to this survey. We saw that 88% of patients who had responded found it easy to get through to the practice by phone. Of the patients who had responded, 94% said the appointment they received was convenient and 95% had confidence and trust in the last GP they saw or spoke to.

Areas for improvement

Action the service SHOULD take to improve

- Improve the level of participation in the patient participation group to ensure the group reflects the practice population.

Outstanding practice

- Highly effective anticipatory care planning for patients with long term conditions.
- Innovative approaches to enable patients in vulnerable groups to access care services.
- The practice took a proactive approach to managing patient admissions to and discharge from hospital.

Chiddingfold Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP, a CQC inspector and a CQC pharmacist inspector.

Background to Chiddingfold Surgery

Chiddingfold Surgery is located in purpose built premises in a semi-rural location. It provides general medical services to just over 4,500 registered patients. The practice has three GP partners, one salaried GP and one GP trainee. Four of the GPs are female and one is male. The team also comprises a practice manager, practice nurses, administration and reception staff, a dispensary manager and dispensary staff. The practice dispenses prescriptions to approximately half of its patients. The practice has a higher proportion of patients over the age of 65 years compared to the national average and serves a population which is more affluent then the national average. The practice has been accredited to provide training to GP trainees.

The practice has opted out of providing Out-of-Hours services to its own patients and uses the services of a local out of hours service.

We visited the practice location at Ridgley Road, Chiddingfold, Godalming, Surrey, GU8 4QP. Chiddingfold Surgery also operates a branch surgery at Dunsfold Surgery, 20 Griggs Meadow, Dunsfold, Surrey, GU8 4ND. We did not visit the branch surgery as part of our inspection.

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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 October 2014. During our visit we spoke with ten members of staff and four patients who used the service.

We viewed eight comment cards from patients who had visited the practice in the previous two weeks and who shared their views and experiences. We also spoke to a representative of the patient participation group and reviewed feedback information from 22 other patients registered with the practice.

Detailed findings

As part of the inspection we observed how staff cared for patients and talked with them. We reviewed care records of patients and examined practice management policies and procedures. We interviewed a range of staff including the GP partners and a salaried GP, members of the practice management team, nursing, dispensary, reception and secretarial staff.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

The practice had implemented systems for reporting and responding to incidents. We reviewed all serious untoward incident (SUI) reports that had been identified and recorded in the previous 12 months. We found they had been completed by GPs and dispensary staff on a range of incidents including prescribing, dispensing and clinical decision making. The reports included actions that had been taken in response to the incidents to reduce future recurrence and improve patient safety.

Learning and improvement from safety incidents

The practice had robust systems in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. A slot for significant events was on the weekly clinical meeting agenda and monthly staff meetings. We saw evidence that the practice had reviewed actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. For example, a recent incident involving the identification of expired medicines within a GP bag had led to a review and adjustment of processes to reduce the risk of recurrence. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children and for domestic violence and another GP partner was the lead for safeguarding of vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles.

Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. Two members of staff we spoke with described recent incidents in which they had reported safeguarding concerns to the GP and the safeguarding lead. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

Systems were in place to ensure regular sharing of information with the local health visitor. Monthly meetings to discuss children of concern were documented in detail.

A chaperone policy was in place and information was clearly displayed in the waiting room, at reception and in consulting and treatment rooms. Chaperone training had been undertaken by nursing staff and two administrative staff who acted as chaperones when nursing staff were unavailable.

Procedures were in place to ensure that criminal record checks via the disclosure and barring service (DBS) were undertaken where necessary. Risk assessments of all roles and responsibilities had been completed to determine the need for a criminal record check. Criminal record checks of staff employed within the practice, were repeated at regular intervals.

Medicines Management

The practice had a medicines dispensary located next to the reception and waiting area. The dispensary was used by patients who lived more than one mile from a dispensing pharmacy. The practice dispensed medicines to over half of its patients. The dispensary had a dedicated manager who was a qualified dispenser and a team of staff who had been trained to dispense medicines safely.

The practice had policies and procedures in place to ensure the effective management of medicines. These policies had been reviewed within the last 12 months. There were standard operating procedures in place for the management of controlled drugs which showed that they were handled in line with legal requirements.

Processes were in place to support the management of repeat prescriptions. Repeat prescription requests could be made in writing to the practice, via the practice website or by completing the repeat prescription request section of a previously dispensed prescription. All repeat prescriptions were generated directly by the patients' own GP. The repeat

prescription was then printed and signed by the GP only after the GP had checked the medicine had been correctly dispensed. The batch number and expiry date of all medicines dispensed to patients was recorded. Private prescriptions, for example, for anti-malaria medicines, were recorded appropriately. Blank prescription pads were stored securely.

Rigorous auditing and review processes were in place to monitor the safety of prescribing and dispensing of medicines. Dispensing errors had been clearly recorded and investigated, with investigation outcomes and learning points noted. We saw that 12 dispensing errors had been recorded within the last 12 months.

The practice received additional support from a practice support pharmacist from the local clinical commissioning group who visited the practice monthly to carry out reviews of medicines prescribing. The clinical commissioning group also provided pharmacists who visited the care homes supported by the practice to undertake reviews of patients prescribed a number of different medicines.

We checked medicines stored in the treatment rooms and fridges and found that they were stored appropriately. There was a clear policy for maintenance of the cold chain and action taken in the event of a potential power failure, included the availability of cool box containers. Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location.

Cleanliness & Infection Control

Systems were in place to reduce the risks of the spread of infection. A designated member of staff was the practice infection control lead person. They demonstrated a good understanding of their role. Infection control policies and procedures were in place. All staff had received training in infection control processes and were aware of infection control practices. The infection control lead told us they provided regular updates within the practice to ensure for example, good hand washing technique.

The practice had ensured they met the requirements outlined in the Department of Health Code of Practice on the Prevention and Control of infections and Related Guidance 2010. Auditing of infection control processes was carried out annually. We saw the last audit had been completed in February 2014. Concerns relating to an external cleaning contractor had been noted within the audit and appropriate action taken.

We observed that all areas of the practice were clean and extremely well maintained. Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitizer and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Spillage kits were available in clinical rooms and in the reception area. We saw records to confirm that patient privacy curtains were laundered every six months. The practice used only single use instruments for all minor operations they performed.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Suitable arrangements were in place to reduce the risks of exposure to Legionella bacteria which is found in some water systems. A comprehensive Legionella risk assessment had been completed. We saw that monthly testing of water temperatures was carried out and water outlets not used regularly were flushed through.

Equipment

A log of all equipment within the practice was in place. Regular service and calibration checks on equipment had been performed. We saw that portable appliance testing had been carried out to ensure the safety of all electrical equipment. Medical equipment including defibrillators and oxygen were available for use in the event of a medical emergency. The equipment was checked daily to ensure it was in working condition.

Staffing & Recruitment

There were robust recruitment and selection processes in place. We reviewed a sample of four personnel files which confirmed that the required pre-employment information and checks had been obtained. These included a curriculum vitae or application form, photographic identity, references, and a professional registration check. The

Good

Are services safe?

practice had undertaken risk assessments for all roles to determine the need for a criminal record check via the Disclosure and Barring Service (DBS). We saw that criminal records checks had been undertaken where appropriate. Up to date records of all staff hepatitis B immunity status were held within the practice.

Monitoring Safety & Responding to Risk

The practice had considered the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of legionella bacteria. All risk assessments had been recently reviewed and updated. We observed the practice environment was highly organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked and sited appropriately.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan in case of emergency. Medical equipment including three defibrillators and oxygen were available for use in the event of a medical emergency. The equipment was checked daily to ensure it was in working condition. All staff had received training in basic life support and defibrillator training to enable them to respond appropriately in an emergency. Panic alarms were installed in all consulting and treatment rooms in case of an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations.

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of weekly practice meetings where new guidelines were disseminated. The implications for the practice's performance and for patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given 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 practice had appointed both GP and nurse leads for specialist clinical areas such as diabetes and respiratory conditions. GPs and nurses were well supported in their specialist roles and described a culture of information sharing, transparency and continual learning. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes. They met regularly with the lead GP for diabetes to review best practice guidelines and both regularly attended shared care meetings with secondary care services.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. A review of 10 case notes included those of five patients with diabetes and five with respiratory conditions. We saw that all patients received appropriate treatment and regular review of their condition. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions.

The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice. For example, we saw the practice had recently responded to NICE guidance relating to the prescribing of medicines to treat epilepsy by brand only. The practice had identified affected patients and all GPs had been informed of the changes required. Prescribing to these patients had been re-audited following a three month period to ensure guidance had been followed.

We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission, end of life care and a 'ceiling' (an upper limit) of care agreed by the patient. Care plans were given to patients to ensure their full involvement and to facilitate sharing of information with other services, such as out of hours services. We saw that care plans had been reviewed every three months or more frequently as required.

The practice referred patients appropriately to secondary and other community care services. The GP partners told us that referrals were regularly reviewed in conjunction with the clinical commissioning group.

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

Management, monitoring and improving outcomes for people

The practice achieved 98.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed well in comparison to the national average. For example, the number of patients with diabetes who had received an influenza immunisation was recorded as 100%, with the national average being 90%.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included gestational diabetes, dispensary services, prescribing of analgesics non-steroidal anti-inflammatory drugs (NSAIDs) and prescribing within a shared cared protocol. We saw the

Good

Are services effective?

(for example, treatment is effective)

results of audits had been shared with the GPs and nurses within regular clinical meetings. Staff spoke of a culture of quality improvement and continuous learning within the practice.

The practice routinely collected information about patient care and treatment outcomes. For example, patients prescribed disease modifying anti-arthritic medicines were monitored by the practice through a shared care protocol with secondary care services. The practice held a register of these patients who were recalled for blood testing when required. An administrator within the practice managed this process with the patient's GP reviewing the blood results within 24 hours of receipt. The process was audited by the GP prescribing lead partner on a three monthly basis.

Effective staffing

New staff followed an induction programme and probationary period, followed by a formal review. This ensured staff were familiar with practice procedures and competent to perform their duties. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding of children and vulnerable adults.

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, the practice had appointed a lead nurse for diabetes and a lead nurse for respiratory conditions. Both lead nurses had undertaken advanced training. The lead nurse for diabetes told us that three monthly shared cared meetings and attendance at an annual diabetes management conference provided opportunities for further updating of knowledge.

Reception and administrative staff had undergone training relevant to their role. For example, one administrator told us they had received training in customer care and data protection. Another administrator who had joined the practice within the last 12 months described their induction programme which included supervision, group training and e-learning programmes. Staff described feeling well supported to develop further within their roles.

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. A practice nurse told us they last had an appraisal with the lead GP partner in January 2014. This had included a detailed review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this. All of the GPs within the practice had undergone training relevant to their lead roles, such as diabetes management and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care.

For example, the practice demonstrated they had developed effective working relationships with two local residential care homes which provided care for patients with dementia. Anticipatory care planning for those patients reflected the patients' wishes relating to hospital admission, end of life care and a 'ceiling' of care agreed by the patient

The practice also provided care for those who attended a nearby residential school for pupils with a range of complex special educational, health and care needs. Shared care agreements were in place for a number of those pupils receiving medicines to treat attention deficit hyperactivity disorder. Annual reviews of pupils' care plans were undertaken and a full audit cycle of the shared care protocol had recently been completed by the practice.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and actioned by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. We saw the practice had a clear audit trail to ensure these processes were completed.

Referrals were made using the 'Choose and Book' service. We saw evidence of the practice's referral process and its effectiveness. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Good

Are services effective?

(for example, treatment is effective)

The GPs within the practice met weekly with the community matron to discuss the local community 'virtual ward' and to respond to the changing needs of patients being cared for within their own homes.

Multi-disciplinary meetings which included palliative care nurses, health visitors, community psychiatric nurses and district nurses were held regularly. An example of the range of patients discussed included palliative care patients, children of concern to health visitors, those experiencing poor mental health and 'at risk' patients including patients who had experienced unplanned admission to hospital.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient 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. Electronic systems were also in place for making some referrals through the Choose and Book system.

Care plans were given to patients to ensure their full involvement in decision making and to facilitate sharing of information with other services, such as out of hours services.

The practice used information received to ensure patient care was being planned effectively. For example, the practice received hospital data on admissions and A&E attendances daily. This information was disseminated to the patient's named GP via email by an administrator within the practice. If a patient remained in hospital for more than seven days, the named GP rang the hospital to discuss the admission and to attempt to facilitate discharge. Patients were contacted by their named GP within 48 hours following discharge from hospital.

Consent to care and treatment

Patients we spoke with told us that GPs and nurses always obtained consent before any examination took place.

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. We reviewed completed consent forms for the insertion of contraceptive implants and minor surgical excisions. These consent forms provided details of the risks presented to the patient and demonstrated informed consent had been obtained.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if required and had a section stating the patient's preferences for treatment and decisions relating to end of life care where appropriate. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All GPs and nursing staff demonstrated a clear understanding of Gillick competencies. (These help GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions, learning difficulties and those experiencing mental health concerns. We saw that medical reviews for those patients took place at appropriately timed intervals. The practice also offered NHS Health Checks to all its patients aged 40-75. An administrator told us that all patients who met the criteria for these checks were being contacted directly by telephone to encourage them to attend.

Health information was made available during consultation. We noted a culture amongst 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 18-25 and offering smoking cessation advice to smokers.

There was a variety of information available for health promotion and prevention throughout the practice, in the waiting area and on the practice website. The practice had also developed an 'information room' for patients which was situated next to the reception and waiting areas. This provided a private room for patients to seek health promotion information and literature. The practice had installed an electronic blood pressure monitor and weighing scales within the room. These provided patients

Good

Are services effective?

(for example, treatment is effective)

with the opportunity to monitor their weight and blood pressure independently or to seek assistance from a member of the practice team for the readings to be recorded.

Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home. The practice had arranged additional Saturday clinics for patients to attend for their flu vaccinations. GPs told us they personally telephoned patients to educate them about the benefits of vaccination and encourage uptake. The practice had recently held a coffee morning in conjunction with a flu immunisation clinic to encourage uptake. We reviewed the Quality and Outcomes Framework (QOF) data for 2012/2013. Data we reviewed showed that 100% of patients with diabetes had a flu vaccination within the six month period between September and March.

The nurse we spoke with us told us there were a number of services available for health promotion and prevention. These included child immunisation, diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD), cervical screening and travel vaccination appointments.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with the way they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice scored above average for its satisfaction scores on consultations with GPs and nurses. Eighty nine percent of patients who responded said the last GP they saw or spoke to was good at explaining tests and treatments. Eighty five percent said the last GP they saw or spoke to was good at involving them in decisions about their care.

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were professional, supportive and caring. They said staff treated them with dignity and respect. We spoke with four patients on the day of our inspection and a representative of the patient participation group (PPG) prior to the inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

GPs and staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. The practice provided a private 'information room' next to the reception area. This room was used to provide privacy for patients who wished to speak to a receptionist or other staff member away from the reception desk. Staff told us it was also used by patients who were particularly upset or anxious prior to or following their appointment with the GP. A sign on the reception desk politely requested that patients waiting to speak with a receptionist stood away from the desk to allow the patient before them some privacy.

Staff respected patients and preserved their dignity and privacy. Privacy curtains were in place in every consultation room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

Patients told us they had enough time during consultations to ask questions and be involved in decisions about their care and treatment. GPs and nurses were aware of what action to take if they judged a patient lacked capacity to give their consent.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 85% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were higher than average in the Guildford and Waverley area.

Patients we spoke to 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.

We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission, end of life care and a 'ceiling' of care agreed by the patient. Care plans were given to patients to ensure their full involvement and to facilitate sharing of information with other services, such as out of hours services. We saw that care plans had been reviewed every three months or more frequently as required.

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. The practice told us they had

identified that increasing numbers of the local population were from Eastern European countries. Information leaflets about contraception were available in languages other than English, such as Polish.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 91% of respondents to the national GP patient survey said the last GP they or spoke to within the practice was good at treating them with care and concern. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website signposted patients to a number of support groups and organisations. The practice 'information room' provided extensive information to support patients and their carers to access support groups. This included a carer's resource file and information pack and information about Action for Carers Surrey, a local support group. Staff told us they were made aware of patients or recently bereaved families so they could manage calls sensitively and refer to the GP if needed.

Outstanding ☆

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 highly responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were well understood and systems were in place to address identified needs.

The clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The chairperson of the patient participation group (PPG) told us they had recently been invited to attend a meeting with the CCG and the practice in order to share information.

The percentage of registered patients aged over 65 years was higher than the average for Guildford and Waverley Clinical Commissioning Group. The practice had recognised this and proactively managed their care. The practice had achieved and implemented the gold standards framework for end of life care. They held a palliative care register and had regular internal, as well as multidisciplinary meetings to discuss the care and support needs of patients on the register and their families.

The practice also held a weekly meeting with the community matron to discuss patients listed on the community 'virtual ward' and who were receiving multi-disciplinary care within their own homes. Patients identified as having had an unplanned hospital admission or an accident and emergency attendance were contacted or visited and their care plan reviewed.

Patients who had been referred for treatment to other services said they were satisfied with the speed and quality of referral. Patients had a named GP to ensure a degree of continuity of care for patients, especially older patients and those with long term conditions.

There had been very little turnover of staff within the practice which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and for those with long term conditions. Patient alert systems were in place which identified patients experiencing poor mental health or other complex conditions which would prevent them from expressing their need for a timely appointment. This also included appointments with a named GP or nurse. Home visits were made to two local care homes by a named GP and to those patients who needed a home visit. The practice also provided care to a nearby residential school for pupils with a range of complex special educational, health and care needs.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients and from the patient participation group (PPG). These included improving privacy at the reception desk, increasing the availability of late morning and after-school appointments and access to on-line appointment booking.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. For example meetings were held every six weeks with the community psychiatric nurse and community matron to share information about those patients experiencing poor mental health, including patients with dementia. Monthly meetings with the health visitor provided the opportunity to share information about children and families of concern.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Innovative methods had been adopted to encourage patients who were in vulnerable circumstances to access primary care services. For example, during a recent measles outbreak, one GP partner visited a local traveller community and spoke with them directly about the benefits of MMR vaccination and the support available to them in accessing care services via the practice.

The practice held a register of patients with learning disabilities. Those patients received annual health checks and regular reviews. The practice worked closely with a local special school to provide enhanced services under shared care protocols for pupils with a range of complex special educational, health and care needs. The GP partner who provided support to the school visited to give regular talks to those pupils. The talks provided information about confidentiality, safeguarding and specific support available to them in accessing the services of GPs and nurses within the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice was located in single storey purpose built premises. The premises and services had been adapted to meet the needs of patients with disabilities. Access to the premises by patients with a disability was supported by an automatic door and a low level front reception desk which had been installed with wheelchair users in mind. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. We noted there were car parking spaces for patients with a disability.

Toilet facilities were available for all patients and contained grab rails for those with limited mobility and an emergency pull cord. Baby changing facilities were available for mothers with young babies. The practice provided a hearing loop to assist patients who were hard of hearing.

The practice had access to online and telephone translation services. We saw notices in the reception area informing patents this service was available. One receptionist who spoke Polish was able to support a number of Polish patients living in the local community.

Access to the service

The practice operated a flexible appointment system to ensure all patients who needed to be seen the same day were accommodated. Patients we spoke with were generally happy with the appointment system. Appointments were available in a variety of formats including pre-bookable appointments, a telephone triage system and a daily 'duty doctor' system. These ensured patients were able to access healthcare when they needed to. Patients told us they could see another GP if there was a wait to see the GP of their choice.

The practice website outlined how patients could book appointments and organise repeat prescriptions online. Patients could also make appointments by telephone and in person to ensure they were able to access the practice at times and in ways that were convenient to them.

The practice was open from 8.15am to 6pm Monday to Thursday and from 8.15am to 5pm on Fridays. Appointments were available from 8:20am to 11am and 1.30-5.50pm Monday to Friday. Occasional Saturday morning appointments were available and some annual flu clinics were scheduled on Saturdays to increase the attendance of patients who were eligible for the flu vaccination. The practice offered a dispensing service for patients who lived more than one mile from a pharmacy.

A number of comments we received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. One patient we spoke with immediately following their appointment had telephoned the practice only a few hours previously, seeking an urgent appointment. The patient told us they had also been provided with a flu vaccination following their appointment, having recently missed a scheduled vaccination appointment.

The practice operated extended opening hours on a Monday evening and Tuesday morning, providing additional appointments that were particularly useful to patients with work commitments. The practice had increased the number of late morning and after school appointments in response to feedback gathered from patients. The 2014 patient survey indicated that a proportion of patients thought that text message reminders of appointments would be a useful addition to the service provided. The practice intended to explore the addition of this service following the recent installation of a new practice software system.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of hour's service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was also provided to patients within the practice waiting area and on the website.

The practice was situated in spacious, modern, purpose built premises on one level. Entry through automatic doors ensured ease of access into the practice and helped to maintain patients' independence. We noted the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Toilet facilities were available for all patients of the practice.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was 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.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Complaints information was made available to patients in the practice leaflet and on the practice website.

A suggestions box within the patient waiting area invited patients to provide feedback on services provided, including complaints. Most patients we spoke with said they had never had cause to complain.

There was evidence of shared learning from complaints with staff and other stakeholders.

We reviewed the practice complaints log. We found there had been three complaints within the last 12 months. The practice had investigated all the complaints and implemented actions and shared learning at staff meetings. The complaints had been investigated and lessons learned.

Are services well-led?

Outstanding ☆

(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, responsive care and to promote good outcomes for patients. The lead GP partner spoke of a commitment to embracing new initiatives and to providing innovative solutions in response to patient needs. The practice benefited from dedicated long serving staff. We spoke with ten members of staff and they all knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these. Staff described a highly supportive and inclusive environment where individual roles were valued.

The GP partners told us that they had recruited a salaried GP within the last year to support succession planning and future sustainability of the practice. They had also considered the implications to their business strategy if plans went ahead for a large new housing development close to their branch surgery.

The staff team understood and shared the vision for the practice and the GP partners had agreed the strategic approach of the business.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with or above national standards.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. Significant events and complaints were shared with the practice team to ensure they learned from them and received advice on how to avoid similar incidents in the future.

The practice had systems in place for completing clinical audit cycles. Examples of clinical audits included gestational diabetes, dispensary services, prescribing of analgesics non-steroidal anti-inflammatory drugs (NSAIDs) and prescribing within a shared cared protocol. We saw the results of audits had been shared with the clinical team within regular clinical meetings. Staff spoke of a culture of quality improvement and continuous learning within the practice.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of legionella bacteria. All risk assessments had been recently reviewed and updated.

Leadership, openness and transparency

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, there was a lead nurse for infection control and two GP partners were the lead for child and adult safeguarding. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. Staff described a supportive and inclusive environment where individual roles were valued. The GPs in the practice emphasised a strong focus on education, learning and continuous improvement for all staff and for patients to be supported to adopt healthy lifestyles.

Staff told us they felt very well supported and knew who to go to in the practice with any concerns. The lead GP partner fulfilled a pivotal role within the practice, providing highly visible, accessible and effective leadership.

The practice had implemented a comprehensive schedule of meetings which provided staff with the opportunity to discuss concerns and disseminate information. Staff told us that there was an open and transparent culture within the practice. They had the opportunity to contribute to the agenda of team meetings, to raise issues within team meetings and on a more informal basis and felt well supported in doing so.

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

Are services well-led?

Outstanding ☆

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

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, comments provided via the suggestion box in the waiting area and complaints received. We looked at the results of the annual patient survey and 57% of patients agreed text message appointment reminders would be useful. We saw as a result of this the practice had plans in place to introduce this service. We were shown a report on comments collected from patients by the PPG during one week of patient interviews in June 2014. Some comments related to the amount of privacy afforded to patients at the reception desk. We saw that signs had been introduced to encourage patients to stand back from the patient in ahead of them whilst waiting near the reception desk. A private information room had also been developed within the reception area for patients wishing to speak to the receptionist in private.

The practice had a very small but active patient participation group (PPG). The PPG had carried out regular patient surveys, produced a patient newsletter and met every quarter. The chairperson of the PPG had recently been invited to attend an annual review meeting with the local clinical commissioning group. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt highly valued as part of the practice team. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed promptly and appropriately. An annual meeting schedule was in place which included clinical meetings, partner meetings and practice team meetings. Staff felt involved and engaged in the practice to improve outcomes for both staff and patients. They told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning & improvement

All GPs and other staff within the practice emphasised a strong focus on education, learning and continuous improvement.

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. We examined four personnel files which confirmed this. All of the GPs within the practice had undergone training relevant to their lead roles, such as diabetes management and child safeguarding. All of the GPs had undergone annual appraisal and had been revalidated.

Systems were in place for recording and monitoring all staff training needs. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, infection control and safeguarding of children and vulnerable adults. Staff told us they also had opportunities for individual training and development. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes.

The practice completed reviews of significant events and other incidents and shared the learning with the staff team to ensure the practice learnt from incidents to improve outcomes for patients. Significant events and incidents were discussed within weekly clinical meetings, GP partner meetings and monthly practice staff meetings.