Balham Park Surgery

Quality Report

Balham Park 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	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 Balham Park Surgery on 18 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, responsive caring services. and well-led. It was good at providing services for all the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health. It was good for providing safe and caring services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised. Risks to patients were assessed and well managed.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. 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 was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and

Summary of findings

owned by all practice staff with evidence of team working across all roles. 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.

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Staff recruitment was in line with requirements.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the Patient Participation Group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure service improvements where these had been identified.

Summary of findings

Patients told us it was easy to get an appointment with a named GP or a 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. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were 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) was active. 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 named GP for all patients over 75. All patients above 90 years and frail patients living alone, without long term conditions also received regular reviews. All patients at risk of falls and needing bone health treatment were referred for specialist care. The practice followed up older patients that were discharged from hospital following emergency admission and their care plans were constantly reviewed. Appointments were flexible to deal with emergencies and the practice had introduced additional winter access clinics which enabled more capacity in the day to see older patients.

The practice arranged and held meetings with the community nurses, the end of life care team and the hospice on a regular basis. The practice worked closely with a local nursing home with two of the GPs visiting daily to review care.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions.

The practice offered patients diagnosed with conditions such as diabetes, epilepsy, coronary heart disease and chronic obstructive pulmonary disease ongoing care monitoring and they had a lead GP for this. These patients were offered annual flu vaccination as per national guidance and reminders were sent for those who had not attended, this included a home visit from the GP. The practice also offered yearly holistic cancer care reviews for patients diagnosed within the past five years. The nurses offered disease management reviews and referred patients to the GPs if change of medicines was required.

Asthmatic patients had regular reviews which included checks to ensure they were using their nebulisers according to instructions. Patients with diabetes were offered a foot assessment and referral to specialist services.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice had a policy to offer same day appointments to children aged 0-12 months. They held weekly child health clinics. This clinic was run by the GPs with the nurse. Women were offered

Summary of findings

six weeks post-natal checks and the practice worked closely with local maternity services and midwives. The GPs examined babies at eight weeks and the practice nurses vaccinated them at eight weeks and continued the childhood vaccination programme. The practice had a visiting health visitor who ran a post natal support group for patients registered at the practice and this offered support for new mothers including those experiencing post natal depression.

The practice held meetings with the local safeguarding teams where a child was identified as being at risk of abuse or neglect. Family planning clinics and Sexually Transmitted Disease advice was also available.

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).

Flexible appointments bookings were available including late evening appointments. Patients could book appointments via the online system.

Patients aged 40 -74 years were offered health checks in accordance with local and national guidance. The practice offered Well Man and Well Woman checks with a nurse. This was an opportunity to discuss any aspect of general health such as dietary problems, stress, alcohol consumption, smoking and all aspects of women`s health; including breast examination, the menopause, cervical smears and contraception.

People whose circumstances may make them vulnerable

Good

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

The practice had a small number of patients with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and all of these patients had received a follow-up. The check also covered general health, social environment, medication review, mood and lifestyle.

Screening services such as smear testing, blood pressure monitoring and smoking cessation advice was offered.

The practice offered advice on availability of HIV testing and other sexual health facilities available locally to their patients.

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)

Summary of findings

The practice maintained a register of patients experiencing poor mental health. These patients were reviewed on a regular basis and had a named GP. Ninety-eight per cent of people diagnosed as having mental health issues had received an annual physical health check while all patients with a diagnosed dementia had received yearly checks.

Reviews involved medication, general health, and psychiatric assessment. The practice made appropriate referrals to the community psychiatric team. Leaflets were available on local services that patients could self-refer to such as “Mind”. The practice offered patients general practice services such as smear testing, breast screening and advice on prostate cancer symptoms. The practice ensured that all staff including reception staff understood the needs of patients by offering one to one sessions with the clinical lead about patients with Mental Health conditions highlighting behaviours to be aware of to ensure care was appropriately delivered. Specialist mental health services were available at the practice from a specialist nurse and these included drug and substance service and input from a psychologist.

Summary of findings

What people who use the service say

We spoke with 18 patients during our inspection and received 32 completed comments cards.

Patients reported being happy with the care and treatment they received. All patients we spoke with were complimentary on the attitudes of all staff and reported feeling well cared for and respected

Patients were complimentary about the practice with many comments referring to the helpful nature of reception staff as well as the listening skills and caring nature of clinicians at all levels. Patients reported being happy with the appointments system which they felt suited their needs.

The 2013/14 GP survey results (latest results published in Jan 2015; 447 surveys were sent out, with 111 returned giving a 25% completion rate) reported that 93% of respondents said the last GP they saw or spoke to was good at listening to them and 96% of respondents showed the last GP they saw or spoke to was good at treating them with care and concern. Ninety six percent of the respondents said the last appointment they got was convenient and 99% found the receptionists at the surgery helpful. All the figures were above the Clinical Commissioning Group average.

Balham Park Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP specialist adviser and an Expert by Experience. The GP advisors and Experts by Experience are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Balham Park Surgery

Balham Practice is a large GP practice based in the South West London area within Wandsworth Clinical Commissioning Group. Since April 2002, the practice has occupied purpose-built premises on the Balham High Road. The Practice is within walking distance for most patients, although parking facilities are limited due to local restrictions. The practice provides NHS primary medical services through a Personal Medical Services (PMS) contract to 18000 patients in the local community.

The Practice population is varied with a range of social classes and ethnic groups. The practice population has a higher proportion of younger adults and children and lower proportions of older people. The local area has relatively low levels of deprivation compared to the National average. The practice serves a culturally diverse population, with the majority of patients being Asian, African and white British. According to the practice they have a high number of young patients who are a highly mobile population.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: diagnostics and screening procedures; family planning; surgical procedures; maternity and midwifery services; and treatment of disease, disorder or injury.

The practice has nine GP partners and nine salaried GPs with a good mix of female and male staff. The practice has one nursing partner and a managing partner. The practice team also consists of three practice nurses, four health care assistants and two GP registrars. Fourteen administrative staff are employed at the practice with some being team leaders for various teams.

The surgery is open all day and core consulting takes place between 8.00am-6.00pm Monday-Friday. Early morning surgeries are offered on Monday, Wednesday and Thursday from 7.00am and late night surgeries on Tuesday, Wednesdays and Thursdays from 6.30pm-8.30pm. The practice operates a routine pre-booked GP Saturday surgery from 9.00am-11.00am. All late nights and Saturdays also have a practice nurse surgery running.

The practice has opted out of providing out-of-hours services to their own patients. A local out of hours service is used to cover emergencies.

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.

Detailed findings

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

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

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

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

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

Before 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 18 March 2015. During our visit we spoke with a range of staff including GPs, managing partner, practice nurse and administrative staff, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We received 32 completed patient comments cards.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. A log record was used to record all incidents. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. The practice categorised their significant events according to the nature of the event. This included after death analysis, significant event audit (SEA) of cancer diagnosis and all other significant events. The after death analysis was conducted for each patient who died and who was on the Practice Supportive Care Register.

We reviewed safety records, incident reports and minutes of meetings for the last two years. These demonstrated that safety issues and incidents were discussed and the practice had managed these consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. The practice held quarterly significant event meetings depending on the category of the event. This enabled in depth analysis to take place by involving specific clinical or administrative leads. Feedback on the discussions were then held with the most appropriate staff teams and learning was shared with all staff groups. It was practice policy to inform the affected patient/s the outcome of the incident investigation including ways in which the new systems had been introduced to avoid future occurrence.

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. All staff told us that incidents were reported using an incident form that was electronic. The form was submitted to the managing partner as soon as possible with a time limit of no longer than 24 hours. Examples of incidents included were a new patient was booked in as "unregistered patient" for a medicine check with the practice nurse. An error occurred when this patient was subsequently registered because they had the same name and were of similar age with another patient who was already registered at the practice. This was discovered by the nurse during consultation and they alerted the reception manager who ensured this was corrected. Following this incident we saw that an email was sent to all staff responsible for patient registrations instructing them to check the name and date of birth of the patient when changing an unregistered appointment to registered. Another event involved a hospital letter that was incorrectly scanned onto another patients electronic record. The patient had a similar name to the patient whom the correspondence referred to. A GP attempted to follow up but noticed the error. After reflecting on this incident the practice highlighted the need to add patient warning messages to the electronic record to highlight to all staff dealing with each patient to be aware of similarly named patients. We saw that the practice were conducting checks to ensure all staff were acutely aware of the need to check names and DOB of all patient documentation prior to scanning onto electronic records.

National patient safety alerts were disseminated by the managing partner to relevant practice staff according to what the alert entailed. Clinical staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example, nurses responsible for administering vaccines told us about recent alerts relating to changes in childhood vaccines schedules. The GPs gave us examples of recent alerts they had received regarding particular medicines being discontinued. We saw records confirming that appropriate action had been taken and in one example this involved auditing records and identifying the affected patients. Alerts were circulated using email. In addition, copies were kept on files for future use and to provide an audit trail.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had dedicated GPs appointed as leads for safeguarding vulnerable adults and children who had been trained and could demonstrate they had the necessary skills to enable them to fulfil this role. The lead for safeguarding children was also the named doctor for the Clinical Commissioning Group (CCG).

Arrangements were also available for cover during the absence of the lead GP to ensure staff had a responsible nominated person to contact. During our inspection we spoke with the GP who was deputising for child safeguarding.

Good

Are services safe?

All staff we spoke with were aware of who the lead persons were and who to speak to in the practice if they had a safeguarding concern. Training records showed that all staff had received relevant role specific training in safeguarding children and adults. All GPs at the practice had received Level 3 child protection training. The practice nurses had received Level 2 child protection training and reception and administration staff had all received Level 1 training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One such example was when a practice nurse had noted that a child had a burn and the family had an alert on the system that identified them as being vulnerable. They had alerted the safeguarding children lead and this resulted in the child and family being referred to the appropriate team .They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details of the local safeguarding teams were easily accessible to staff through display on notice boards.

The GPs responsible for safeguarding issues at the practice liaised regularly with the local Multi-Agency Safeguarding Hub (MASH) and with the health and social services teams. The GP told us they were providing timely information for any case reviews. The health visitor we spoke with on the day of our inspection told us they had built a good working relationship with GPs at the practice and they communicated concerns effectively to safeguard children.

A chaperone policy was in place and visible in the consulting rooms. Chaperone training had been

undertaken by all nursing staff, including health care assistants. It was practice policy only to use clinical staff as chaperones. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperoning duties had Disclosure and Barring Service (DBS) checks carried out.

The practice used a flagging system to identify all children and families who were on protection plans and Looked after children (LAC) to ensure they were continuously assessed and monitored as required. Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including scanned copies of communications from hospitals. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. All GPs we spoke with mentioned that the practice ensured vulnerable patients, child and families were seen by the named GP to ensure continuity. However in cases when this was not possible any GP or nurse who provided care to a child or vulnerable adult had the duty to inform the named GP .We tracked booked appointments and noted that this was happening.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records that confirmed the fridge temperatures were checked and recorded. All recordings for the past 12 months were within the required range. Action to take in the event of a potential failure was available and staff were able to confirm this to us.

Systems were in place to check medicines were within their expiry date and suitable for use. A check list was available and the practice nurses used this to ensure all checks were accurate. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Vaccines were administered by nurses using current directives that had been produced in line with legal requirements and national guidance. We saw a copy of directives from the CCG and evidence that nurses had received appropriate training to administer vaccines. All vaccination batch numbers were recorded in the patient records to ensure that if an alert was raised on the vaccine they could easily identify patients who had been affected.

One GP partner was responsible for monitoring prescribing within the practice and subsequent costs. There was a protocol for repeat prescribing which was in line with national guidance and was followed by the practice. Patients could request repeat prescriptions online and in writing. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Good

Are services safe?

Cleanliness & Infection Control

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

The practice had an infection prevention and control policy that was in line with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. An infection control policy and supporting procedures were available for staff to refer to in the form of a handbook, which enabled them to plan and implement measures to control infection. The lead for infection control was one of the practice nurses who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training on infection control specific to their role and annual updates thereafter which the practice manager monitored to ensure they were in date. Audits had been carried out for the last two years and any improvements identified were completed on time. Clinical practice meeting minutes showed the findings of the audits were discussed.

Hand hygiene techniques signage was 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 germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice had carried out a risk assessment that had identified a low risk. This risk assessment was continuously updated last one being on 13 February 2015.

Equipment

Staff 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 of October 2014. A schedule of testing was in place. We saw evidence of calibration of equipment such as weighing scales and the fridge thermometer. This had been completed in January 2015.

Staffing & 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 criminal records checks via the Disclosure and Barring Service.

The managing partner 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 they were enough staff 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. Newly appointed staff had this expectation written in their contracts which we viewed. Due to the size of the practice, no locum staff were used. Instead the practice employed regular staff that would cover during absence and sickness. These staff were familiar with the practice and so enabled good continuity of care.

Staff told us there were usually enough personnel to maintain the smooth running of the practice, and there were always enough staff on duty to ensure patients were kept safe. The managing partner showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & 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 a health and safety risk assessment of the building and the environment by NHS property services. The practice had a health and safety policy. Health and safety information was available for staff and contained in a handbook. The practice had identified health and safety representatives who were responsible for ensuring adequate safety measures were being followed.

Clinical risk assessments were also completed annually by the practice. Areas assessed included patient access, medicines management, referrals, infection control, records management and incident reporting. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. The risk assessment was reviewed annually to ensure actions were followed up.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment. The defibrillator was available for all practices in the building and arrangements were in place for it to be checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac emergencies, anaphylaxis and hypoglycaemia. Processes were also in place to check 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. Risks identified included power failure, lack of physical space to potentially manage the rate at which the patient list size was increasing, adverse weather, unplanned sickness, disease outbreak and access to the building. The document also contained relevant contact details for staff to refer to including the telephone numbers of all staff and those of other practices within the area.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice showed us data from the local Clinical Commissioning Group (CCG) of the practice's

Performance for antibiotic and NSAID prescribing which compared well with other practices.

Staff we spoke with were aware of the need to keep updated with guidelines in order to improve care. The practice kept information folders that were easily accessible to staff through internet links with guidance from the National Institute for Health and Care Excellence (NICE), British Medical Journal (BMJ) and Department of Health (DH), amongst others. We noted that the practice had nominated leads that were responsible for each clinical area and it was their responsibility to ensure that these were continually updated. One such example was a meeting that was planned to update clinical staff on the new Atrial fibrillation guidelines produced by NICE. The GPs told us that they used local guidelines and care pathways from the local Clinical Commission Group (CCG) and other directives to improve patient care. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The practice had an overall QOF score of 857 points out of 900 for the previous year.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. The practice also had a low accident and emergency attendance rate compared with other practices in the CCG. This was evidence of good access to the practice by patients and the continual needs assessment such as the introduction on winter flu clinics for children and elderly patients.

All GPs we spoke with used national standards for the referral of patients. Patients with suspected cancers were referred and seen within two weeks. The practice had appointed an administrative team who followed up these referrals to ensure patients' treatment was not delayed. This was a unique service by a team put in place by the practice especially to ensure that patients secondary care journeys were as smooth as possible. We noted that staff were responsible for following up referrals and liaising with patients to ensure they had received and acted on hospital appointments offered.

The practice undertook risk profiling of their patients. Care plans had been completed for patients identified by the new enhanced service recommending that 2% of the risk population. Patient records looked at confirmed that this was in place.

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

Management, monitoring and improving outcomes for people

The practice had systems in place to monitor and manage outcomes to help provide improved care. GPs and the managing partner were actively involved in ensuring important aspects of care delivery such as significant incidents recording, child protection alerts management and referrals and medicines management were being undertaken suitably.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The electronic recording system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Regular clinical meetings nursing and medical staff took place with multi-disciplinary attendance to ensure learning and to share information. There was evidence that patients with dementia, learning disabilities and those with mental health disorders received suitable care with an annual review of their health and care plan.

The practice had a system in place for completing clinical audit cycles. The practice showed us 11 clinical audits that had been completed between April 2014 and March 2015. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. One such

Good

Are services effective?

(for example, treatment is effective)

example was an audit on Atrial fibrillation. National Institute for Health and Care Excellence (NICE) had recommended risk stratification of all patients with Atrial Fibrillation (AF). In response to this the practice had found that a number of their patients with AF were not adequately coded as recommended by NICE. Following this the practice coded the patients accordingly. A re- audit had been conducted and this found a much improved score for patients.

Other examples included audits to confirm that the nurse who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance. The nurse had conducted an audit between April 2014 and March 2015.The purpose of the audit was to monitor and improve infection rates in patients who had received minor surgery A total of 116 patients had procedures. The patients were asked to return for a histology sample following the surgery. Results confirmed that only one patient had infection following an excision procedure. The nurses also conducted inadequate smear audits. These were completed yearly with the last one being at the end of 2014. The results demonstrated that the inadequate rate was within the acceptable range for the CCG but the practice used each staff member's rates to identify training needs.

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.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this. An example of this had been when a GPs position was ultimately terminated due to some clinical and communication issues that could not be resolved. This was identified through patient feedback, complaints, Mentor observation of the GP and videoing consultations with patient permission. Despite trying to facilitate improvement, the GP was unable to meet the required standards expected by the practice.

The practice was involved with other local practices in reviewing their performance. This involved meeting with the medicines management team from a local cluster of practices. Referral data and prescribing data was discussed with improvement areas highlighted. This formed part of a peer review process and data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

The practice had an effective recruitment and induction programme. The practice had an induction pack that was given to all new staff and a practice booklet that set out valuable information about the practice. All new salaried doctors had a nominated mentor. We spoke to salaried doctors who commented on the thoroughness of the induction programme including on-going support. Staff in other roles such as administrative also had similar programmes. Reception staff were inducted over a six month period. Their progress was continually monitored and this included listening to recorded patient calls to ensure they were providing adequate services. 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 confidentiality awareness.

All GPs were up to date with their yearly continuing professional development requirements and a number had been revalidated in the last few months. The organisation kept records for the performers list with the General Medical Council and they were both up to date. The practice had records supplied by the practice nurse that showed their registration with the Nursing and Midwifery Council (NMC) was current. An internal alert system was used by the managing partner that alerted them in advance when the nurse's registrations required renewing to ensure this was done on time.

Records showed that all staff had received an appraisal within the last 12 months. Both records reviewed and discussions with staff confirmed that the appraisal process was linked to professional development. The practice nurses received appropriate training updates that enabled them to carry out specific roles such as vaccinations, minor surgery and other specialist role and this training was offered regularly within the local cluster or arranged externally by the practice.

Working with colleagues and other services

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. On receipt these were stamped to show date received

and processed on the day by a designated administrative staff member. The practice used a computer system that alerted the GPs or nurses of the results allocated to them and the action required. The system would highlight an alert if this had not been followed up by a specific time. Staff explained that these checks were undertaken on a daily basis to ensure all results due were acted on. All staff fully understood their role and the expectations of the practice on dealing with patient results promptly.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients such as those with end of life care needs or children on the at risk register. These meetings were attended by community nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice also benefited from being located close to other services such as health visitors and with community nurses in the same building. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We spoke with members of the community nurses teams who confirmed that they worked closely with the practice and this improved communication and resulted in better patient outcomes.

Information Sharing

Information was available in the reception about the patient summary care records and who else may access the information within them. Sharing some specific patient information with other services allowed external services to work with patients as soon as possible. Patients were given details of how to opt out of the service and restrict access to their summary care record if they did not want their information shared. The practice also benefited from having an internal information technology team. They dealt with all enquires relating to patient records and electronic access.

The practice used several electronic systems 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. Electronic systems were also in place for making referrals, and the practice made 90% of referrals last year through the Choose and Book system which was amongst the highest in the CCG. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Through connecting for better health some health information was available to other health care professionals. This allowed records to be updated by professionals treating patients and for all those involved in someone's care to have influence over the best care and treatment for individual patients.

Consent to care and treatment

The practice had polices on the Mental Capacity Act 2005 and the application of Gillick competencies legislation. (Gillick competence is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). The GPs were able to explain to us the importance of seeking consent and situations when they had to apply the Mental Capacity Act and Gillick competency while helping patients to consent to care and treatment.

Records reviewed indicated consent was sought prior to treatment and situations where the GPs had to involve other patient representatives when seeking consent for treatment. Patient records evidenced that the practice had made appropriate referrals to Social Services for Mental Capacity Assessment when required.

Health Promotion & Prevention

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and 50 out of 55 were offered an annual physical health check. Practice records showed 90% had received a check up in the last 12 months. The remaining 10% had declined this check.

The practice had also identified the smoking status of 86% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 27 in the 2013/2014 period, which was second highest in the CCG. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those

Good

Are services effective?

(for example, treatment is effective)

receiving end of life care. These groups were offered further support in line with their needs. The practice also had systems for identifying 'at risk' groups so that they could offer additional support. For example, the practice aimed to follow up people who had been discharged from hospital within two days and practice records showed that this system had been successfully completed for 99% of people.

The practice's performance for cervical smear uptake was 80% for the 2013 /2014 period which was above other practices in the CCG. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following-up patients who did not attend screening.

National screening for bowel cancer and breast cancer was managed by St George's, Hospital. The practice worked with the hospital to send reminder letters to patients who failed to attend screening appointments and non-responders. For the year 2013/2014 609 patients had been screened for breast cancer and 498 had been screened for bowel cancer.

The practice offered a full range of immunisations for children, adults and travel, in line with current national guidance. The practice's performance on childhood immunisations during the 2013/2014 period, for children aged three months to 12 months were as follows; Dtap/IPV/Hib (Diphtheria, Tetanus, acellular pertussis (whooping cough), poliomyelitis and Hemophilus influenza type b) 94%, Meningitis C and PCV (Pneumococcal conjugate vaccine) 71%, Hepatitis B 92% and MMR (measles, mumps, and rubella) 88%; not all were above the CCG average and the practice was aware that a number of their patients with young children were very mobile .The practice had a clear policy for following up non-attenders by the named practice nurse and GPs. We saw records that confirmed this was being followed.

We also observed that the practice had a dedicated breastfeeding zone in the surgery waiting room that enabled mothers to breastfeed in private. This supported guidance from the United Nations, Children's Fund (UNICEF) for Baby Friendly Initiative that encourages support for breastfeeding mothers. The practice had also identified the number of women in the locality who were at risk of post natal depression. To support this, the practice had an attached health visitor that ran a mother and baby group. They worked closely with the GPs to identify women who were affected and needed extra support. Located within the practice was a drugs and alcohol service. The practice worked closely with this service and referred patients who required specialist interventions.

The practice offered patients a variety of health promotion leaflets. The practice nurse offered a range of health promotion clinics, including child immunisations, travel information and vaccinations, chronic disease management for asthma, diabetes, epilepsy, and HIV. Due to the high prevalence of diabetes and stroke in the local area, additional clinics were run by the nurses to manage these conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2013/14 GP survey results (latest results published in Jan 2015; 447 surveys were sent out, with 111 returned giving a 25% completion rate) 93% of respondents said the last GP they saw or spoke to was good at listening to them and 96% of respondents showed the last GP they saw or spoke to was good at treating them with care and concern. Ninety six percent of the respondents said the last appointment they got was convenient and 99% found the receptionists at the surgery helpful. All the figures were above the Clinical Commissioning Group average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 18 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 all consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

The practice had a chaperone policy and details of how to request a chaperone were displayed in areas easily accessible to patients. Records confirmed that staff had completed the chaperone training at the practice. Staff we spoke with were able to fully explain what the role involved.

We saw from staff training records that all non-clinical staff had attended training in equality and diversity and information governance. Initial training had been undertaken and was refreshed at given points in time. This training helped support staff when dealing with patients face to face and when managing patient information.

Care planning and involvement in decisions about care and treatment

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 90% 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 above average compared to CCG area/ national. The results from the practice's own satisfaction survey showed that 94% of patients said they were sufficiently involved in making decisions about their care.

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.

A notice board in the practice reception area displayed photographs of all members of staff and their roles. Patients commented that this helped them to form a more meaningful relationship with all staff.

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, 96% of respondents to the Patient Participant Group (PPG) survey said they had received help to access support services to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

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. this also included a video from the patient group on what happens in their monthly meetings, the benefits of attending them and how to get involved in their activities / influencing practice decision making.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered a number of specific enhanced services to support the needs of the local population. This included supporting patients in avoiding unplanned admissions and offering extended opening times.

Each enhanced service was led by a clinician. The practice held continuous learning days to ensure learning in specific areas. Learning took place throughout the organisation and this was shared with the team through practice meetings. The practice used specially designed templates for care pathways and this helped to improve patient care. For example the practice had a chronic disease template. This had the most current guidance from NICE and it clearly demonstrated the pathway that clinicians followed. Records viewed showed that GPs were using the templates to structure care plans.

Care plans were completed in a holistic way ensuring that all healthcare professionals involved with someone's care had access to the information and could update the information as required. This ensured the plans remained current as the patients' needs changed.

The practice used the choose and book system to make referrals to secondary (hospital) services. This ensured the patient had influence over where their care and health care needs were met. The practice had a comprehensive system for making referrals. This was managed through an administrative referrals team within the practice. There was a clear policy that outlined the process of making referrals such as the investigations that a clinician needed to have carried out before making a referral.

Patients who were too ill to attend the surgery were visited at home by the GPs.This also included home visits for flu vaccines for patients who were housebound. Staff told us that longer appointments were available to patients that needed them such as elderly, patients experiencing poor mental health or those with chronic disease and we saw examples of this on the bookings screens where appointments for up to half an hour had been booked.

The practice had a Patient Participation Group (PPG) that had been existence for over ten years. The practice had initially funded the group to help it operate. The group had an introduction video that was played in the reception area. This provided patients with information such as how to become a member and advertising upcoming events.

The group consisted of 12 to 15 active members that were reflection of the local community. We saw that the practice worked closely and valued the PPG involvement in care delivery and decisions. Some members of the group we spoke with on the day of our inspection pointed to a notable success during a recent CCG budgeting review during which they undertook significant research which they understood demonstrated to the CCG, the need to maintain a particular service at the surgery. Members consider this research and lobbying activity as an increasingly important function. They also reported that the practice was very supportive of their work and listened carefully to their views whilst respecting and indeed encouraging independence.

The PPG at the practice had organised a number of health education events in the last two years, which were all reported to have been notably successful. An example was an event to raise awareness of dementia which attracted more visitors than the venue could accommodate. The PPG continued to organise health events with external speakers twice a year.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example services for asylum seekers, those with a learning disability or travellers, unemployed, carers and patients with HIV. Reception staff had all been given training that enabled them to provide valuable information at that first contact in reception to these group of patients.

The practice had access to online and telephone translation services and a GP and nurse who spoke locally used languages.

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 last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice had fully automatic opening doors of a width sufficient to accommodate most user needs including large

Good

Are services responsive to people's needs?

(for example, to feedback?)

Wheelchairs and other mobility aids. The reception desk included a lowered section suitable for wheelchair users.

The practice was situated on the ground floor for patient consultations. There was lift access to the first and second floors.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of 60% English speaking patients though it could cater for other different languages through translation services.

Access to the service

The surgery was open all day and core consulting takes place between 8.00am-6.00pm Monday-Friday. Early morning surgeries are offered on Monday, Wednesday and Thursday from 7.00am and late night surgeries on Tuesday, Wednesdays and Thursdays from 6.30pm-8.30pm. The practice operates a routine pre-booked GP Saturday surgery and from 9.00am-11.00am. All late nights and Saturdays have a practice nurse surgery running. 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 provided to patients on notice boards and contained in the practice leaflet.

All patients we spoke with were satisfied with the appointments system. They confirmed they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. The GPs operated a telephone triage system where patients with urgent needs would be offered same day appointments or a consultation over the telephone.

The majority of the practice population were English speaking. Staff told us that they requested interpretation services if a patient need them. The interpretation service was available via the telephone.

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 and there was a designated responsible person who handled all complaints in the practice and this was the managing partner.

We saw that information was available to help patients understand the complaints system .This was included in the practice information leaflet and displayed in the reception area. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at 42 complaints received in the last 12 months. All complaints had been dealt with in a timely manner and had been resolved. We also noted all complaints had been discussed and shared with all staff at practice meetings. The practice had a policy to follow up all patients who had complained by asking them to complete a satisfaction survey. The purpose of this was for the practice to monitor and improve on their complaints management based on this feedback. We reviewed the most recent satisfaction surveys and noted that the majority of patients who had complained were `very satisfied' with the way the practice had handled their complaint.

The practice reviewed complaints on an annual basis to detect themes or trends. These were split into complaints relating to GPs, nursing staff, administration staff, reception and the general management of the practice. We looked at the report for the last review in 2014 and found that the main themes were around, lack of time during consultation, demonstrating standards of hygiene are being maintained, failure to check labels on sample pots and errors with appointment bookings. We saw that the managing partner had shared all the complaints with all staff and learning points for the practice had been identified such as training had been implemented for reception staff on how to handle sample pots.

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 as stated in a statement on its website-The Balham Park Surgery philosophy was to provide high quality care and services to patients, while meeting their requirements as individuals and for the local population. The practice vision and values included to offer a friendly, caring and good quality service that was accessible to all patients. We found details of the vision and practice values were part of the practice's five year business plan. These values were clearly displayed in the waiting areas and in the staff room and were contained in the practice personal development plan that was given to all staff.

All staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these. The practice had been awarded 'Investors in People' for training and developing staff and were disability symbol users. On the day of our inspection, the staff gave us a presentation introducing the practice. We saw that staff at different levels were part of these presentations and their input was valued by the organisation.

Governance Arrangements

The practice had nominated leads for clinical and non-clinical roles and they took responsibility within that area for example there was a team leader in the reception and administration team and they were responsible for the day to day managing of the teams. Clinical leads took overall responsibility and accountability of their nominated areas such as child protection leads and cancer referrals lead.

The practice also benefited from having a manager who was a partner and nurse partner responsible for nursing and governance respectively. This provided a rigorous structure to the organisation as all staff groups were represented fully. For example monthly clinical risk meetings were held for the separate staff groups i.e., nursing medical and administrative staff This enabled discussions to be focused though all learning from all incidents and complaints were shared with all staff collectively.

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 national standards. QOF for the year 2013/2014 was 857 out of 900 points. The practice had completed full audit cycles such as inadequate smears and audits to confirm that the nurse who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance .These audits were used to improve care and outcomes for patients.

The practice had arrangements for identifying, recording and managing risks. The managing partner showed us risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice nurses told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement. For example in the inadequate smear tests.

The practice had implemented a comprehensive schedule of meetings which provided staff with the opportunity to discuss concerns and disseminate information. These meetings were divided into clinical, administrative, significant event analysis, complaints and a general meeting for all was held. Staff told us they had the opportunity to contribute to the agenda of team meetings, to raise issues within team meetings and felt well supported in doing so. We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff told us they felt very well supported and knew who to go to in the practice with any concerns.
The managing partner fulfilled a leadership role within the practice, providing highly visible, accessible and effective support.

Leadership, openness and transparency

The leadership structure of the practice was clear to all staff. All 25 staff we spoke with told us who the lead person was for each area at the practice and for the whole organisation. From our discussions with staff we found that the organisations senior management including leads were accessible. The organisation presented as being open with all staff and as much as they had different departmental leads; a flat structure of management was still maintained.

Are services well-led?

Good

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

Staff told us that there was an open culture within the practice and they had the opportunity to, and were happy to raise issues at team meetings or at any time with the practice manager or GPs.

The managing partner was responsible for human resource policies and procedures. We reviewed a number of policies, such as disciplinary procedures, induction policy and management of sickness which were in place to support staff. All policies were up to date. Staff we spoke with knew where to find these policies if required and they were contained in the development pack given to all staff at induction.

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

The practice had an active Patient Participation Group (PPG) which had been active for a number of years. Findings from PPG surveys and information on how to be involved with the PPG was shared with patients via a newsletter or on the practice website. The PPG contained representatives from various population groups; including the retired and some ethnic minority patients. The PPG were consulted and took part in all surveys conducted throughout the year and meet monthly. Feedback from surveys resulted in changes to appointment times and availability and the cleaning schedules at the practice had also been increased after findings from the surveys.

The practice had also introduced the Family and Friends Test. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. We saw in December 2014 out of a total of sixty responses out of seventy patients selected that they would be extremely likely to recommend the GP practice to friends. The practice published a hand out with responses from the team to any issues raised. The hand-out was available in the waiting room for patients.

The practice had gathered feedback from staff generally through staff meetings and appraisals. All the staff we spoke with said the practice had an open environment and they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice held very regular meetings at least three per week for staff where they supplied food. They also take part in social events together to maintain team morale.This was an opportunity for all staff to get together and share a meal as well as discuss any issues they might have. All staff we spoke with reported on how useful the sessions were as they were an opportunity to bond as a team.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice nurses told us that they were supported to attend a local nurses' forum were information was shared which improved their knowledge and practice.

Significant events including accidents, incidents and complaints were discussed and improvements agreed and shared within the team. Practice staff all told us they wanted the practice to succeed. Regular training was delivered by different methods that included e-learning and internal and external speakers on practice related topics. The practice reviewed the previous 12 months performance and reinforced improvement action. Plans were developed with a continued focus on practice developments and improvements.

The practice was a GP training practice for the Health Education South London. There were two trainees working at the practice at the time of our inspection. We spoke with one of the trainees who told us they were well supported by the GP partners who regularly reviewed their clinical performance.

The practice had an internal peer review and peer appraisal for all GPs. The first year a GP was in post the appraisal was conducted by their allocated Mentor, thereafter they choose their peer appraiser .The deputy to the managing partner collected 360 degree feedback electronically. This was given to the appraiser and shared with the GP. Objectives identified out of an internal appraisal were fed into the practice professional development plan.

All GPs also worked with other members from the CCG. GPs who attended the meetings told us case studies were shared and performance against enhanced services and contractual obligations were discussed. The CCG and representative GPs agreed solutions for group wide performance improvements.