Victoria Medical Centre

Quality Report

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Date of inspection visit: 04 December 2014
Date of publication: 06/08/2015

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
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

We carried out an announced comprehensive inspection on 4 December 2014. Overall the practice is rated as outstanding. Specifically, we found the practice to be outstanding for providing effective and responsive services and for being well-led. It was also rated as outstanding for providing care for older people and working age people (including those recently retired and students).

The practice was rated as good for providing safe and caring services. It was also rated as good for providing care for people with long term conditions; families, children and young people; people whose circumstances make them vulnerable and people experiencing poor mental health. Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- A proactive approach to anticipating and managing risks to people who use their services was embedded and was recognised as the responsibility of all staff.
- 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). Information about how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear vision which had quality and safety as the top priorities. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

The practice had worked with a Professor from the nearby university to trial an innovative approach to

Summary of findings

improving the wellbeing of working men in their population to decrease stress and distress by delivering high quality counselling and acupuncture to over 150 male patients over an 18 month period. This work was shortlisted for a BMJ award and is likely to influence local commissioning. Seventy eight percent of the 150 men reports improvement in their wellbeing following the course.

The practice sees more than 350 pregnant women a year and deliver very full antenatal services from an integrated team of GPs, practice nurses and health visitors. This team recognised that many women had not taken folate in early pregnancy and took action to address this and in the process produced a leaflet entitled "Thinking about getting pregnant but not right now. An A-Z of pre-pregnancy care". This leaflet won a best practise award from the Primary Care Women's Health Forum. 10,000 copies have been circulated across GP practices and the local hospital and is used throughout Central London CCG practices.

The practice has a PPG with 800-900 members and has a twitter account with around 100 followers. The practice acts on the feedback in a number of ways to improve services to patients. The Patient Participation Group (PPG), facilitated by the practice, arranged for patient learning sessions to be held. These were advertised in the newsletter and in the waiting area. Presentations had been made by guest speakers on coping with stress and managing diabetes. Exercise classes took place at the practice including over 60s sessions on Monday and Friday. A patient at the practice had recently started an evening 'shape up' group with the support of the practice. The aim of the group was to help patients manage their weight, improve their health and become more active. The practice had been designed with space for these events, which took place in a large room adjacent to the reception area.

The practice hosts and supports a monthly Memory Café for patients with dementia and their carers and family members. The practice has actively sought feedback from those attending and has been rewarded by very high patient satisfaction reports.

The practice has employed a "Link Worker" for the elderly. This individual identifies and where appropriate visits all over the age of 75 to offer support and information about health and social care support that is available locally and signposts patients to services to prevent falls and receive shingles and flu vaccination programmes.

The continuing development of staff skills and knowledge is recognised as integral to ensuring high quality care. Staff were proactively supported to acquire knowledge and share best practice. Weekly practice meetings included a learning element. Guest speakers and healthcare specialists were invited to talk about their area of expertise. An example of this was a talk by a local 'youth gang' outreach worker. The aim of this was to raise awareness of gang culture which existed in the area and how this may affect patients' health.

The practice had worked with eternal providers to assess the interface between the public and their reception team, the first contact points for patients attending the practice. This project resulted in the practice producing patient group specific packs to help them access not only the practice but all local health services to try and improve the most appropriate use of those services.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. The whole staff team met annually to review incidents and complaints with the aim of consolidating their learning and improving patient care. There was a lead for safeguarding adults and child protection. There was a system to highlight vulnerable patients on the patient electronic record. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. The practice was using innovative and proactive methods to promote outcomes for patients by educating and encouraging self-care. Innovative steps had been taken to improve pre-conception care and the wellbeing of working age men. Both had been audited and demonstrated improve outcomes for theses population groups. A practice employed link worker ensure that people over 75 made best use of the practice and local health and social care services.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. 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. Throughout the inspection we observed an open, patient-centred culture. The practice had placed specific emphasis on supporting patients to take care of their emotional and psychological health.

Summary of findings

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding 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 very large patient participation group (PPG). In conjunction with the PPG the practice had arranged for health promotion sessions to be delivered to patients on common health concerns such as coping with anxiety and managing diabetes. The practice reviewed the needs of its local population and had responded to a concern regarding the psychological health care needs of men. A service for men called 'ATLAS' had been initiated and evaluated. Male patients were offered acupuncture and counselling, with a choice of male or female counsellor. Sessions took place at the practice two evenings a week and Saturday mornings. The sessions were evaluated by a London University in July 2014; men were interviewed and asked to complete questionnaires. One of the key findings was that seventy eight per cent of patients said they felt better after their Atlas sessions. The practice had very good facilities and was well equipped to treat patients and meet their needs. The practice pays a local charity to rent paintings from a "library" and as a result appears more like a gallery than a surgery. Information about how to complain was available and easy to understand. The practice web site provided an active email link for patients to report a concern or a complaint. The practice responded quickly when issues were raised. Patients also had the option to sign up to the practice 'twitter' account where they could give feedback on the service. The practice held an annual review on incidents and complaints. This was attended by the whole staff team with the purpose of identify themes and key points of learning from these events.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. It had a clear vision and strategy. Staff understood the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There was strong collaboration and support across all staff who had a common focus on improving quality of care and peoples experiences. There was a clear proactive approach to seeking out new ways of providing care and treatment. The practice had a wide range of policies and procedures to govern activity. Clinical meetings took place monthly where the management of patient care and safety was reviewed. National Institute for Care and Excellence (NICE) Guidelines were discussed at clinical meetings.

Summary of findings

The practice has a long history of undertaking audit and working with others on innovative projects to enhance the experience and outcomes for their population. There were systems in place to monitor and improve quality and identify risk. High standards were promoted and owned by all staff and teams worked and learnt together across all roles. The practice proactively sought feedback from staff and patients, which was acted on. The large patient participation group (PPG) was active and worked in partnership with the practice to improve outcomes for patients. A twitter account had around 100 followers.

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 good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Lead GPs had a special interest in a range of long term health conditions and a practice nurse who led in this area had received training in how to treat patients with long term conditions. Ninety eight per cent of those with diabetes had received regular health checks including a foot examination.

People with long term conditions

Good 

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Families, children and young people

Good 

The practice is rated good for the care of families, children and young people. There was a safeguarding lead, suitable policies and procedures were in place and staff had completed training in child protection to the appropriate level. Staff were aware of their responsibilities to report concerns. The electronic patient records had a 'flag' to identify those at risk.

Dedicated ante/post natal and child health clinics were held on a Thursday morning at the practice. A 'drop in' baby weighing session was also available at this session. A waiting room and consultation rooms on the first floor were allocated for the sole use of families

during the clinic. A lead GP and lead nurse ran the clinic. Clinical staff met regularly with health visitors to review the families on the vulnerable antenatal pathway, where a risk had been identified to the health and wellbeing of the unborn child.

The practice had a system to remind patients when childhood immunisations were due. The practice provided emergency on the day appointments in the morning and afternoon which meant children sent home from school unwell could access the GP if required. The practice staff had regular meetings with midwives and health visitors. Clinical staff were aware of Gillick competency (when a child is able to consent to their own medical treatment without the need for parental permission).

Ninety percent of children aged two years had received their Dtap/ IPV/Hib vaccine which is an injection to boost protection against five different childhood diseases. This was close to the national figure of 93%. Eighty-eight per cent of children had received the first dose of the mumps, measles and rubella (MMR) vaccine and 90% the second dose. The practice was achieving slightly below the national MMR rate of 93%.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The percentage of people registered at the practice in employment or full time education was higher than the national average, seventy one percent of people in comparison to 60% nationally. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended hours two evenings a week and opened every Saturday mornings. The practice was proactive in offering online services (appointments and repeat prescriptions) and telephone consultations as well as a full range of health promotion and screening that reflects the needs of this age group. The practice had identified that there was a high level of need for working age males to receive support in managing stress and anxiety. In response to this health promotion sessions and talks were offered on Tuesdays evenings and Saturday mornings when people of working age could attend. The practice had also identified the need for making pre-conception health information widely available. This was now shared across all practices and sexual health clinics in the CCG area.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people. A practice nurse was the lead for working with homeless people and worked with patients and staff from two hostels for homeless people in the local area. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It informed vulnerable patients how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia. Ninety two per cent of people in this category had a comprehensive agreed care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The elderly care link worker was able to monitor older people in the community who may be experiencing poor mental health. A monthly 'memory café' session was held at the practice for people with dementia. The lead GP for mental health worked with a local psychiatric hospital, and liaised with staff regarding people who were registered as patients at the practice. The practice had informed patients experiencing poor mental health how to access various support groups and voluntary services. The practice had identified areas of risk in the local population. One of these areas was high levels of stress and poor mental health amongst working age males. The practice had responded by offering health sessions on managing stress and anxiety.

Summary of findings

What people who use the service say

We spoke with five patients during our visit and received 33 comment cards, completed by patients who visited the practice during the week before the inspection. The comment cards indicated patients were happy with the service they received. They said that staff were polite, helpful, kind, caring, understanding and supportive. Patients commented that staff were professional and said they appreciated the care they received from staff at the practice. Patients we spoke with made positive comments about the practice. Patients told us that communication and interaction with staff was good and staff were caring and respectful. One patient told us about meetings, health promotion events and exercise classes which were organised and available at the practice. The results from the 2014 GP patient survey indicated that 78% of patients described their overall experience as good and 77% of patients said that the last GP they saw or spoke to was good at treating them with care and concern.

Outstanding practice

The practice had worked with a Professor from the nearby university to trial an innovative approach to improving the wellbeing of working men in their population to decrease stress and distress by delivering high quality counselling and acupuncture to over 150 male patients over an 18 month period. This work was shortlisted for a BMJ award and is likely to influence local commissioning. Seventy eight percent of the 150 men reports improvement in their wellbeing following the course.

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of expertise. An example of this was a talk by a local 'youth gang' outreach worker. The aim of this was to raise awareness of gang culture which existed in the area and how this may affect patients' health.

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Victoria Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Lead inspector, a team leader from CQC Disclosure and Barring Service (DBS) Department and two GP specialist advisors.They are granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Victoria Medical Centre

The main surgery is located in the Victoria area of central London, and provides a general practice service to around 13,500 patients. The practice had a General Medical Services (GMS) contract with NHS England for delivering primary care services to the local community. The practice also operates a branch surgery at Lees Place which is located in Mayfair. Victoria Medical Centre was moved to its current premises in 2007 after operating for approximately twenty years in a previous location. The staff team were involved in the design and layout of the building. The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; family planning; maternity and midwifery services diagnostics and screening and surgical procedures. The practice provided an anti-coagulation enhanced service for the locality. The practice is open six days a week from 8.00am-6.00pm Monday, Wednesday and Friday and provided extended hours from 8.00am to 8.00pm on Tuesday and Thursday. The practice was open from 9.00am to 1.00pm every Saturday. An out of hours service with access to a duty doctor was used when the surgery was closed. Patients were directed to this service by the practice answer phone. The telephone number for the out of hours service was also available in the patient information leaflet and on the practice website. The patient population groups served by the practice are diverse. Clinical staff supported two hostels for homeless people. The practice also served patients from the local business community and government institutions. The practice was located in a mainly white British residential area with their branch surgery, Lees Place located in an affluent area of Mayfair. The staff team at the practice comprises of four GP partners (two female and two male) and six salaried GPs (four female and two male). There are six practice nurses including a lead practice nurse and an INR (warfarin therapy) lead nurse. The practice employs both an elderly care link worker and a care navigator as members of the extended team. The practice is a training practice. One registrar and a Foundation Year 2 doctor were undergoing their GP training at the practice. The practice manager is the lead for the day to day management of the practice and the clinical team are supported by eight receptionists and five administrative staff. There were no previous performance issues or concerns about this practice prior to our inspection. Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Why we carried out this inspection

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

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

Detailed findings

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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the practice and asked other organisations, the local Clinical Commissioning Group and NHS England and to share what they knew. This information did not highlight any significant areas of risk.

We carried out an announced visit on 4 December 2014. During our visit we spoke with a range of staff including GPs, the practice manager, practice nurses, reception and administrative staff and we spoke with four patients who used the service. We reviewed comment 33 cards where patients who visited the practice in the week before our inspection gave their opinion of the services provided. We observed how patients were being cared for. We looked at the provider's policies and records including, staff recruitment and training files, building and equipment maintenance, health and safety, infection control, complaints, significant events and clinical audits.

Good

Are services safe?

Our findings

Safe track record

Arrangements were in place to identify risks and improve patient safety. National patient safety alerts were received on the electronic recording system and shared at the weekly clinical meeting. Staff we spoke with were aware of the incidents and issues that required reporting, including safeguarding concerns and accidents, and were clear about their role to report issues to the GP, practice or business manager. There were suitable policies and procedures for safeguarding, infection control and health and safety. The whole team was involved in reviewing safety at the practice.

Learning and improvement from safety incidents

The practice had suitable arrangements in place for reporting, recording and monitoring serious untoward incidents and accidents. A record had been made of incidents which had occurred in 2014 and records evidencing these had been discussed at weekly meetings. Incidents were clearly recorded on a specific template. The template included a section for recording the 'insight and learning' gained by the member of staff involved, changes and improvements to be made and planned action to rectify the situation. For example, the practice nurse had noticed conflicting guidance had been issued regarding the administration of influenza vaccinations. As a response, the Patient Group Directive Coordinator was contacted for clarification. The outcome of this was an amendment to the guidance issued to practices on this particular patient group directive (PGD). We saw the minutes of the Significant Events Annual Review which took place in 2014. This was attended by the whole staff team. The purpose of this review was to examine the learning which had taken place as a result of incidents and complaints. Some of the learning points from the review were that early liaison and interaction with patients was essential in ensuring any remedial action was effective. As a result of the last annual review, monthly meetings were set up to consider and revise practice procedures. Two practice procedures which had been revised were the Practice Appointment and Practice Prescription Protocol.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. GPs had completed child protection and safeguarding training to Level 3, practice nurses to Level 2 and reception staff Level 1. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for child protection and adult safeguarding teams were accessible to staff. The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. The practice nurse was available to chaperone patients if this was requested. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice regularly reviewed the care of all children who had been discharged from the accident and emergency department. A multi-disciplinary meeting took place every three months to review vulnerable families and young people. The team consisted of the child protection and safeguarding lead, GPs, and health visitors. The team also reviewed patients on the 'vulnerable antenatal pathway', where a risk had been identified regarding the health and welfare of the mother and unborn child.

Medicines management

Medicines were stored securely and suitable systems were in place for checking medicines. Those we looked at were in date. Medicines were checked monthly with systems to rotate stock to ensure older medicines were used before they reached their expiry date. Records of the temperature of fridges where vaccinations and immunisations were

stored were taken daily. Staff we spoke with said a policy was available for the safe storage of vaccines and this was being adhered to. Staff were aware of the required temperature range and were aware of the actions they needed to take if the temperature went outside of these. The practice did not stock any controlled drugs. The clinical staff we spoke with were aware of prescribing guidance and knew how to access this information on their desktop computer. The lead pharmacist for the clinical commissioning group (CCG) was based at the practice. The GP lead for medicines management and the pharmacist worked together to ensure prescribing practice was reviewed. The pharmacist attended clinical meetings and training records evidenced that the pharmacist presented in house medicines management training to all clinical staff. Prescriptions were stored securely and handled in line with national guidance. The repeat prescribing protocol was in line with local and national guidance. Clinical staff had clear guidance to follow when they reviewed patients' medicines and wrote repeat prescriptions. GPs at the practice reviewed all requests for a repeat prescription prior to the prescription being authorised. Systems were in place to ensure annual medicines reviews took place for patients with long term conditions. Patients could use the on-line repeat prescription service, deliver requests in person or post them to the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and tidy. Clinical staff attended regular meetings where infection control procedures at the practice were discussed. The practice had a named lead for infection control and infection control protocols were in place. Practice protocols included how to manage spillages, needle stick injuries and the safe disposal of sharps. An infection control audit had been carried out by NHS London and we saw the last infection control audit report for the year 2013. Infection control audits were undertaken by an external provider. The practice had scored 100% in 2013. Shortly after our inspection a further planned infection control audit was undertaken and the practice again scored 100%. Personal protective equipment including gloves and aprons were in place and we saw that there was a supply of these in all consultation rooms. Clinical waste was stored separately from domestic waste in designated storage containers. We saw that a contract was in place for the removal of waste by a licensed carrier. The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices and the defibrillator. Equipment had been calibrated in July 2014.

Staffing and Recruitment

We looked at the employment records of the two most recently employed members of staff, one clinical and one non clinical which contained evidence that appropriate recruitment checks had been undertaken prior to employment. We saw that proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) had been obtained for these staff. The practice had a recruitment and selection policy that set out the required standards for staff. This had been reviewed in October 2014. Staff were provided with a hand book which set out their terms of employment and performance expectations.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw records of building maintenance, for example annual maintenance of the lift and fire safety equipment which had both been serviced in 2014. The fire safety policy had been reviewed in 2014 and we saw a record of weekly fire alarm checks and quarterly fire drills.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

Suitable arrangements were in place to deal with emergencies. Emergency equipment including medical oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) were available in the practice. Anaphylaxis equipment and guidance (for the treatment of allergic reactions) was available in each consultation room. Emergency medicines were easily accessible and securely stored and staff knew where these were kept. Processes were 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 which was kept under review. This was available to staff electronically. Staff had clear guidance on actions they should take in the event of a range of emergency situations including a power cut, flood and adverse weather conditions.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated. We attended a clinical meeting on the day were of the inspection and observed that clinical staff discussed all elements of patient care including assessment and effective treatments.

The practice had identified specific needs of some of their population groups; the elderly were socially isolated, working age men had a high level of stress, younger women were not being given pre-conception health promotion and advice. The GPs had taken steps to improve outcomes for all three groups and others.

The GPs and nursing staff we spoke with individually were clear about their reasons for the treatments prescribed. They were up to date with best practice guidelines from NICE and local agreements. We saw they used locally agreed prescribing guidelines. The GPs each had a lead area of clinical interest such as long term conditions, elderly care, women's health and child health. Practice nurses had a lead clinical area for warfarin therapy, childhood immunisations, working with homeless people, and long term conditions. Staff in this role were given time to keep up to date with guidance including attending relevant training and providing training and support to colleagues. GPs told us that they made referrals and provided treatment depending upon patient need. We saw no evidence of discrimination when staff made decisions regarding care and treatment and patients were referred on the basis of need. Junior members of the clinical team informed us that they were supported by experienced colleagues in decision making. They told us there was an 'open door' policy and they felt comfortable to ask for a second opinion prior referring a patient to a secondary health care service.

Management, monitoring and improving outcomes for people

The practice had a system for undertaking clinical audit cycles. There was a culture of using audits to improve patient outcomes that dated back many years. Examples of recent clinical audits included an audit on the quality of Accident and Emergency discharge summaries during 2013 and 2014, an audit on referrals to secondary care and an audit on emergency admissions to hospital for patients with Chronic Obstructive Pulmonary Disease (COPD).

The practice reviewed up to forty consecutive accident and emergency discharge summaries to ascertain the quality of the information. The audit reviewed information regarding diagnostic investigations and medical procedures. No further action resulted in this audit as overall the quality of discharge summaries was good.

The practice had audited referrals to secondary care during the period 2011 to October 2013. The practice identified areas where referral rates where high, for breast lumps, urology and dermatology. The practice took action to evaluate individual GPs referral rates and invite specialists to clinical team meetings. An example of this was a local consultant who presented information on common urological problems and prostate cancer and discussed when a referral to secondary care was necessary. When this data was audited again there was a reduction in referral rates to these three clinical specialities.

The practice had set up a COPD clinic in November 2012 as a result of an increase in patients on the COPD register. Prior to the clinic being set up 15% of high risk patients had an emergency admission to hospital between November 2011 and October 2012. Following the re audit of this information the number of admissions has decreased to approximately 7%.

The practice had achieved 99.8% of Quality and Outcomes Framework (QOF) points in 2013-2014. QOF is the voluntary incentive scheme used to encourage high quality care, with indicators to measure how practices were caring for patients. All patient referrals for secondary health care were processed through the CCG patient referral service. Prior to this, referrals were reviewed at the practice to ensure that the correct referral process was followed. Reception staff were designated the task of following up referral requests, if the practice had not been notified of an appointment for the patient within two weeks of the referral.

A diabetic clinic took place once a week on a Friday; this was run by the lead GP and a practice nurse. Patients were

supported with insulin initiation and were also referred to a dietician for support with their diet. The practice was above average for arranging health checks for patients with diabetes and had met QOF targets in this area.

Clinical meetings were held weekly and attended by GPs, nurses, a pharmacist and the care navigator. The care navigator assisted patients to identify the most suitable health and social care services to meet their needs. A clinical meeting was being held on the day of the inspection and was attended by both CQC GP specialist advisors. The clinical team reviewed NICE guidance and received an infection control update. Prescribing practice and non-steroidal anti-inflammatory drugs were reviewed. There was a focus on the treatment of urinary tract infections and the pharmacist offered guidance on recommended treatments. Information on breast cancer and the use of HRT was shared by one of the GPs who had recently attended a meeting on women's health.

Two health visitors, employed by the local NHS community health care trust, were based at the practice which facilitated communication with practice staff. Ante/post natal and child health clinics were held on Thursday morning between 9:00 and 1:00pm. The clinic was run by a lead GP and lead practice nurse and the two health visitors. The clinic was for eight week baby checks with the GP and childhood immunisations, and a baby weighing drop in session was available. The health visitors conducted the baby development checks. Ninety percent of children aged two years had received their Dtap/IPV/Hib vaccine which is an injection to boost protection against five different childhood diseases. This was close to the national figure of 93%. Eighty-eight per cent of children had received the first dose of the MMR vaccine and 90% the second dose. The practice was achieving slightly below the national MMR rates. Ninety-three percent of children aged two received the second dose of MMR in England in 2013-14.

During the clinic a waiting room on the first floor was solely allocated for parents and babies. On the day of the inspection we observed this waiting area which was a clean, comfortable, and spacious and a calm place for mothers and babies to wait for their appointment.

The practice employed a link worker for elderly patients over the age of 75. The aim of the link worker was to identify patients who were at risk of isolation, or who were frail and were at risk of falls or other issues that may affect their safety. The link worker visited patients in their home and worked with practice staff and social services. The link worker could make referrals to voluntary organisations such as befriending and advocacy schemes with the consent of the patient. Patients had access to the link worker's direct telephone number in case they needed to make contact. The link worker had direct access to the GPs to report any concerns about an elderly patient.

The practice was one of three GP services in the Victoria area of London to participate in a pilot scheme called 'care navigator'. The care navigator referred patients an appropriate service and followed up appointments to ensure patients were receiving the correct care. Two GPs offered medical care to a nursing home for 38 residents and visited the home weekly. Each patient had an end of life care plan.

Wellbeing exercise classes were held at the practice twice a week for the over 60's. These were free to patients and were run by a physiotherapist. A monthly 'memory café' session was held at the practice for people with dementia.

Patients requiring emotional and psychological could be referred to a counsellor who worked at the practice. Patients could also be referred to a Cognitive Behaviour Therapist who was also based at the practice. In addition to this patients who needed further support could be referred to the Improving Access to Psychological Therapy service.

A practice nurse was the lead clinician for mental health and homeless patients and liaised with the mental health rapid response team and a psychiatric hospital in the local vicinity. The practice had reviewed staff development in the area of caring for patients with mental ill health and had identified further training. Two clinicians had attended a work shop on caring for people with a personality disorder; this training had also been given to reception staff.

We were informed that reception staff were aware of vulnerable patients and how to contact their carer if this was required. The practice had a policy for managing missed appointments. Patients who were identified as vulnerable were exempt from this. When patients in this group had missed three appointments their care would be reviewed by the GP partners.

The practice arranged learning seminars for staff twice a year. A 'youth gang' outreach worker was invited to a recent

seminar to talk to staff about the growing issue of gangs in the local area and the safeguarding implications for young people. The focus of this awareness session was around sexual exploitation and substance misuse.

Clinicians promoted male health. Posters were displayed in toilets with the headline 'how is your man?' as a prompt to partners to encourage health promotion. GPs at the practice had the option of referring male patients to the Atlas Wellbeing Service for men. The practice had recognised increasing stress levels and mental ill health in the male population with a high suicide rate in comparison to females.

The lead for the Atlas service was one of the GP partners at the practice. The service was open to all male patients. Counselling sessions and acupuncture were available to patients on set evenings of the week and Saturday mornings. Patients had a choice of male of a female counsellor. An evaluation of the Atlas Wellbeing Service for men was undertaken by a London University. Qualitative data was collected for the period March 2013 to July 2014 to measure outcomes for patients. The patient's psychological state was measured at the beginning and end of treatment There were a number of key findings regarding the outcomes for patients. Two of the findings were that GPs played a key role in referring and encouraging men to attend the service and the majority of patients had benefited from the treatment. Seventy eight per cent of patients said they felt better after their Atlas Sessions, 13% felt no change and 4% felt a little worse.

Effective staffing

A training needs analysis had been completed for clinical managerial and administrative staff employed at the practice. We looked at staff straining records and saw staff were up to date with annual basic life support and child protection. We saw the practice learning and development record for the period 2012 to 2014. The record demonstrated that the practice held regular training and learning sessions which were part of staff meetings. An example of the areas of practice looked at were medicines management, gynaecology, and carers awareness training. Regular clinical updates were recorded for this period in areas such as osteoporosis, antenatal care, dermatology and prescribing.

The practice initiated and hosted educational and training meetings which were held regularly on Thursday afternoon. The sessions were open for staff and other professional associates of the practice. Guest speakers were invited to these sessions; some of the topics presented between September and November 2014 were managing the death of a patient, management of osteoporosis, and a drug and alcohol service update from a substance misuse worker.

Annual appraisals were carried out for all staff. Doctors had an annual appraisal and were working towards their revalidation. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). Salaried GP appraisal included 360 degree feedback from team members and patients.

Practice nurses informed us they had monthly nurse meetings where they reviewed clinical practice which included annual immunisation updates. Nurses informed us that were supported to develop their skills. For example, one nurse had completed a training course in the management of long term conditions and informed us that she now felt more confident in the treatment of patients with cardiopulmonary disease and diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All staff we spoke with were clear about their role and said the system worked well.

The practice participated in monthly multidisciplinary meetings to discuss the needs of patients with complex health needs including those receiving end of life care. The GPs, practice nurses and elderly care link worker met with the district nurse team, social services and the community matron to discuss how they jointly managed the care of some patients.

The feedback we received from staff at the practice was good. All of the staff we spoke with commented that they worked in a supportive environment where learning was promoted and communication with colleagues was good.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice actively worked with many voluntary and private sector groups in the locality and was adept at obtaining grant funding to support additional services for their patients and shared the learning from this with other practices in the CCG.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to record and manage patients care. Paper records were no longer kept and historical patient records had been scanned onto their electronic record. All staff were trained in how to use the system. The practice used electronic systems to communicate with other providers. There was a system in place for ensuring patient discharge summaries were coded and scanned onto their record. The summary was then forwarded to the lead GP and practice nurse.

The electronic recording system had an indicator system to show if a patient was vulnerable and if a child was on a child protection plan. Reception staff gave us examples of how they supported some vulnerable elderly patients and carers to make appointments at convenient times for them.

There was a clear process in place for managing referrals. We saw the log book which was used to record and follow up urgent referrals under the two weeks wait rule. This process was managed by reception staff and meant that patients were kept informed about the progress of their referral.

Consent to care and treatment

Clinical staff were clear about requirements to seek consent prior to providing treatment. They said they sought verbal consent before carrying out an examination. Patients gave written consent before having minor surgery; records we saw confirmed this. Staff were clear about their responsibilities around the Mental Capacity Act (2005). They were aware of when best interest decisions would be needed and how to ensure children were legally able to consent to treatment by demonstrating an understanding of Gillick competence.

We looked at the results of the minor surgery questionnaire which were gathered from 99 patients who had attended minor surgery during 2014. Ninety nine per cent of patients said staff were good at explaining tests and treatments and involving them about decisions in their care.

Health promotion and prevention

Clinical staff demonstrated a good knowledge of the health needs of the local population and used this to determine health promotion. The Patient Participation Group (PPG) was actively involved in patient health promotion. This information was contained in the PPG quarterly newsletter. We saw that the Autumn newsletter provided advice for patients on protection from influenza. Flu vaccination performance for the practice was better than the national average. Eighty per cent of patients over the age of 65 had received their flu vaccine compared to the national average of 73%. Seventy nine per cent of eligible women attend the practice for their cervical smear test the England average for the uptake of this test was 81%.

Two PPG events were advertised in the newsletter; 'coping with anxiety' and 'Managing Diabetes'. Patients were able to attend these sessions which were hosted at the practice with a guest speaker who was a specialist in this area.

Grant funding had been achieved to support the delivery of initially twice weekly evening exercise sessions for those over 60 years of age. Due to its success this now happens three times a week and is supported by both a senior physiotherapist and a nutritionist and is fast becoming an important part of local community activities.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national patient survey in which patients gave positive feedback. According to the national GP survey 77% of patients said that the last GP they saw or spoke to was good at treating them with care and concern. This was below the national average practice score of 85%.

We received 33 patient comment cards from patients who visited the practice during the two weeks before our visit. Eleven comments cards had been completed by patients from the branch surgery Lees Place Medical Centre. Patients indicated they were satisfied to very happy with the service they received at the practice. They said that staff were polite, helpful, kind, caring, understanding and supportive. Patients commented that staff were professional and they appreciated the care they received from staff at the practice.

We spoke with five patients who commented that communication and interaction with staff was good and staff were caring and respectful. One patient spoke to us about meetings, health promotion events and exercise classes which were organised and available at the practice.

We saw staff demonstrated good knowledge of patients, greeting them by name, speaking with them politely and respectfully.

The reception desk in the main practice was in a large open plan patient waiting area. This area was designed to allow for some privacy for patients checking in as the patient seating area had been placed at a distance to the reception desk. A children's play area was also located in reception along with baby changing facilities and an accessible toilet.

Care planning and involvement in decisions about care and treatment

Patients we spoke with said they were involved in making decisions about the care and treatment they received; the doctors and nurses listened to them and took time to explain things to them in ways they understood. One patient commented that GPs always contacted them or 'phoned back'

when they said they would, and another patient commented that communication between the different healthcare services they used was good.

Seventy-six per cent of respondents in the national GP patient survey 2014 said the doctor involved them in their care and treatment compared to the clinical commissioning group average which was 77%.

Staff told us they had access to face to face and telephone interpreting services when required and patients were informed of the availability of this service.

Reading material was present in all waiting areas, ranging from medical information to general interest magazines. Information on patient groups (PPGs) and CQC literature was also present on waiting room tables, along with well set out information boards the content of which was current.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with confirmed that they would know where to find support if required. They told us that staff they interacted with were always caring and provided emotional support. The practice had a range of services to support people with psychological and emotional problems. These included an in house counsellor and cognitive behavioural therapist. Staff at the practice informed us that they had noticed an increase in poor mental health and stress within their male patient group and recognised that some men preferred not to seek help. In response to this support sessions had been set up for male patients including a PPG event on coping with anxiety. This was open to the whole patient group.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice knew the needs of the local population and was responsive to those needs. We saw the services provided were flexible to meet patient's needs. Staff spoken with were aware of local services and support groups to refer patients to when required. The practice had an active PPG who met monthly. There are 800-900 regular members and this number is increased by the use of a twitter account with around 100 followers. The practice's electronic email list has 1800-2000 patient users.

We met with a member of the PPG who said the aim of the PPG was to inform, educate and support patients. The PPG representative informed us how this had been achieved and gave examples of how the practice had organised talks for patients on areas of health care that mattered to them, for example in conjunction with the PPG the practice had arranged for health promotion sessions to be delivered to patients on common health concerns such as coping with anxiety and managing diabetes.

We saw the PPG annual report for 2014. The reported looked at the results of a patient survey undertaken in January and March 2014. Questions for the survey were designed and discussed by the PPG. Changes made following patient feedback included the addition of new members to the PPG group, and the option of feedback by email and twitter. Patient information sessions had been promoted, an example of this was a talk given by the chair of NHS England about recent changes in the NHS.

The practice had looked at the needs of the working age population specifically the male patient population. The Atlas service for men service had been designed to promote psychological wellbeing for male patients who presented with stress and anxiety type symptoms. The evening exercise classes for those over 60 was in direct response to patient feedback through the PPG.

The practice patient survey results were compared for the years 2013 and 2014. Overall the results indicated that there was an increase in satisfaction level in comparison to the previous year. Higher percentages of patients said they would recommend the practice to a friend, had a positive experience and were satisfied with the service. Eighty per cent of patients said they had been able to see a GP urgently when necessary. The survey had identified the reception service as being an area for improvement.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had a designated nurse to work with people who were homeless and had raised staff awareness on vulnerable groups in the community. The practice had access to online and telephone translation services. The premises and services had been designed to meet the needs of patient with disabilities. Access to the practice was on ground level and lifts were available to some consultation rooms which were situated on the first floor. Accessible toilet facilities were situated on the ground floor.

Access to the service

The practice was open six days a week from 8.00am-6.00pm Monday Wednesday and Friday and provided extended hours from 8.00am to 8.00pm on Tuesday and Thursday. The practice was open from 9.00am to 1.00pm on Saturday. An out of hours service was used when the surgery was closed and patients were directed to this by answer phone. The practice offered a range of advance and on the day emergency appointments for patients. Appointments could be booked up to one week in advance; two GPs were on duty during each session to offer same day appointments.

Children and vulnerable adults were offered emergency appointments. Clinical staff informed us that patients were able to present more than one medical issue during their consultation. Patients could use the on-line appointment booking system or telephone to make appointments.

Seventy per cent of respondents to the National patient survey said it was easy to get through on the phone and 66% said they usually waited less than 15 minutes when they arrived for their appointment, this compared to the CCG average of 85%. Eighty two per cent of respondents said the last appointment they made was convenient to them.

The practice had invested in the building design which incorporated features known to promote patient wellbeing. Although the reception area was open plan, the space was extensive and seating was placed at a distance from the

reception desk to allow some privacy for patients when booking in. The design of the building utilised natural light as well as being brightly decorated. There was ample seating with the added provision of a café area with access to drinks, magazines and health promotion material. There was also a children's play area. Art work which was on loan from Paintings in Hospitals could be seen throughout the practice. Staff informed us that the ambiance of patient areas was designed to provide a pleasant waiting experience and aid calm.

Listening and learning from concerns and complaints

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

Information on complaints was available on the practice website with an 'active' email link to enable patients to report any concerns. The practice manager was responsible for dealing with complaints.

We viewed three complaints which had been received during 2014. The complaints record indicated that in each case the complaint was investigated and a learning outcome for staff was recorded. For example one learning outcome was to ensure information was given to patients in a clear manner to avoid misunderstanding and manage patient expectations.

Records of complaints showed they had all been responded to and the patient was satisfied with the outcome. Learning from complaints was shared with staff at weekly practice meetings, any common themes were addressed by additional training.

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

We spoke with a range of staff and they all knew the vision and values of the practice and what their responsibilities were in relation to these. Staff outlined the aims of the practice as being continuity of care, good access to appointments and customer service. A systematic approach was taken to improving care by reviewing patients safety, listening and responding to feedback from patients and training and developing staff.

Governance arrangements

There were clear governance arrangements and staff we spoke with were aware of the reporting structures. They told us managers were approachable and provided support to them when required. Staff had allocated lead areas of responsibility. For example there was a GP lead for safeguarding, diabetes, and women's health. All staff with lead responsibilities and those who we spoke with were clear of their area of responsibility within the practice and said they had received the training to support their role.

Staff met regularly to discuss the management of the practice and patient care. Partners met weekly and there was a weekly meeting for all clinicians where case studies were presented and guest speakers were invited to present selected topics. Administrative staff and reception staff met monthly. Meeting minutes were stored on the practice's shared computer drive.

The practice had policies and procedures in place which were available on a shared drive so all staff could access them. We looked at the staff recruitment procedures and the staff handbook. These gave clear guidance on the responsibility the employer and employee. There was a business continuity plan in place which took account of potential disruptions to the service.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing above national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

Leadership structures were clear and there was an open and transparent culture. The GP partners and the practice manager were responsible for the day to day running of the practice. The principal GP was the clinical lead and the practice manager the administrative lead. The practice had worked with a wide range of external agencies and had won a number of grants to enable them to undertake projects and deliver improved outcomes for their patients. Some of the innovations had been shared across the locality. One project had been shortlisted for a BMJ award a second had won an award from the Primary Care Women's Health Forum. Staff were aware of these structures and those in leadership positions. Staff told us they were supported to carry out their duties, they felt supported by each other and said they felt confident to approach a colleague for a second opinion or advice on patient care. Administrative staff said that they were always updated about developments in the surgery and attended regular meetings.

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

The PPG had a membership 800- 900 who were on the mailing list and participated by email, and an active group of six PPG members who met regularly. The terms of reference for the PPG were on the practice website. The PPG produced a newsletter twice a year giving information on health updates and learning events. Staff informed us that a twitter account had recently been set up for patients. At the time of the inspection around 100 patients were followers of the practice on twitter and were able to give feedback about the practice using this method.

A staff team away day was organised annually. We looked at the record of the last away day and saw that staff had looked at the development of customer care, clinical care and had reviewed organisational and staffing matters.

The practice conducted an annual patient survey. We were told that the results of the surveys were analysed and if identified, improvements were made to the service. We looked at the results of the survey for 2014 and saw that there was an increase in patient satisfaction from the previous year. For example, 89.3% said they would recommend the practice to a friend, in comparison to 87% the previous year. Eighty nine per cent of patients found

Are services well-led?

Outstanding ☆

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

their experience to be positive compared to 87% the previous year. We also saw that as a result of feedback from the previous year patient health education and promotion sessions had been arranged.

Management lead through learning and improvement

Staff were supported to learn and develop on a continual basis. Training and development opportunities were available and a staff training needs analysis had been completed. The training needs analysis outlined the generic and role specific learning which had taken place and identified training topics for future learning. We looked at staff files and saw that staff had an annual appraisal to identify personal areas of development.

Clinical meetings were held every Thursday. Clinical staff brought details of individual cases and recent learning to share with their colleagues. Meetings were often attended by a speaker who presented information on a specific health care condition or community social service. Patients and staff had the opportunity to meet and learn together at educational events which took place at the practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. Significant events and complaints were reviewed at an annual meeting where learning and development was identified.