

Pitshanger Family Practice

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 09.30 on 7 January 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Risks to patients were assessed and well managed. An external infection control audit had taken place and the practice demonstrated they were compliant with infection control guidelines.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The majority of staff had received training appropriate to their roles.
- Information for patients on looking after their health was included in the practice newsletter which was issued four times a year.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had responded to the results of patient surveys and was offering extended opening hours and had given information to patients on the option of a telephone consultation with a GP at the practice.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Ensure all staff are aware of the chaperone policy and the role of the chaperone and ensure training is provided to members of staff who undertake a formal chaperone role.

- A training and development plan should be put in place for new staff to ensure they have the right skills and knowledge.
- Provide detailed awareness training for all staff on safeguarding adults at risk.
- Ensure audit cycles are completed to drive continual improvement.

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?

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. The staff team reviewed incidents and complaints approximately every two months to ensure that learning points had been consolidated. Lessons were learned and communicated widely to support improvement.

An infection control inspection and audit had been carried out by NHS North and East London Commissioning Support Unit in 2014 and we found the practice had complied with the recommendations of this audit.

Suitable arrangements were in place for safeguarding and child protection. The practice had a system for the safe recruitment of staff. A chaperone policy was in place and the majority of staff we spoke with were familiar with the policy. However we did note that some clinical staff were not fully briefed on the policy and had not received training on the role of the chaperone.

Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice had a schedule in place for maintaining the building and calibrating medical equipment. Risks to patients were assessed and well managed. Staff told us there were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely and the practice had a system in place for undertaking clinical audit and staff spoke positively about the culture in the practice around audit and quality improvement.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice monitored unplanned hospital admissions and as a result patients who had been discharged after an unplanned admission were invited for a thirty minute appointment with their GP. The practice was due to introduce patient summary care records which would be accessible to other health providers. The practice had given patients information on what this would mean and their options. Information on health

Good



Summary of findings

promotion, vaccinations and screening programmes was available in the practice newsletter. Information for patients on looking after their health was also included in the practice newsletter which was issued four times a year.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The majority of staff had received training appropriate to their roles and any further training to manage patients care needs. A staff meeting for the whole practice team took place four times a year. There was evidence of appraisals and personal development plans for all staff and worked with multidisciplinary teams including supporting the delivery of the Gold Standards Framework for end of life care.

Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for two aspects of care, these were being treated with compassion, dignity and respect and involvement 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.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. Seventy nine per cent of patients who responded to the GP Patient Survey said they were able to get through to the practice and make a same day appointment with a GP. As a result of the patient participation group (PPG) survey the practice had introduced extended hours. The practice was open from 07:30 on Monday morning and closed late on Thursday at 19:00.

The practice ascertained through their patient survey that 73% of patients were not aware that they could request a telephone consultation with a GP. Reception staff were prompted to remind patients of this option and information on telephone consultations was printed on patient prescriptions.

Good



Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Staff at the practice 'attended skills for care training' on equality and diversity. A telephone translation service was available for patients who requested support with communication.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice regularly reviewed learning from complaints to ensure improvements in practice had been implemented.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy and staff we spoke with were clear about the practice 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 patients, which it acted on. The patient participation group (PPG) was active and information on practice developments and health advice was included in a newsletter and on the practice website. Staff received regular performance reviews and attended staff meetings, training and peer clinical review groups.

Good



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

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Patients over the age of 75 had a named GP. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with complex needs. The practice kept a register of patients with dementia, of these 82% had received a face to face review of their care within the preceding twelve months. Fifty five per cent of patients over the age of 65 had received the seasonal flu vaccination.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Good



People with long term conditions

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.

Unplanned admissions to the accident and emergency department were monitored and recorded. Patients who had an unplanned admission to hospital were invited in to the practice for a 30 minute consultation with a GP and a care plan was developed in partnership with the patient, the patient kept a copy of this and a copy was also kept in the patient record. Post discharge procedures were in place and the practice nurses provided post hospital discharge services such as wound care and the renewal of dressings.

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.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation

Good



Summary of findings

rates were high for all standard childhood immunisations. Ninety seven per cent of children registered with the practice had received their booster immunisations. Children and young adults between the age of ten and eighteen who did not have a complete MMR immunisation record were followed up by the practice and offered an appointment with the practice nurse to receive their immunisation.

Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired 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 had on an on line appointment booking system. Patients had the option of booking an appointment outside of normal working hours twice a week. Appointments were available from 7:30 on Monday with extended hours on Thursday when appointments were available until 19:00.

The practice used the Choose and Book system (a national electronic referral service for booking hospital outpatient appointments) to enable patients to arrange their preferred date of choice of their initial appointment after referral. The nurses and health care assistant provided health promotion and screening, and immunisations. Seventy nine per cent of eligible women had attended for a cervical smear.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had a register of patients who had a learning disability. It had carried out annual health checks for people with a learning disability.

Staff knew how to recognise signs of abuse in vulnerable adults and children. However, we saw that not all staff at the practice had received training in safeguarding vulnerable adults.

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.

Good



Summary of findings

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). Eighty seven per cent of patients with a diagnosis of mental illness had a documented agreed care plan in their record. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

People experiencing poor mental health were offered flexible services and appointments and we saw evidence that an adjustment had been made to offer patients with a mental health diagnosis later appointment sessions in the day. We saw an example of an alert on the electronic patient record informing reception staff that selected patients at risk of deteriorating mental health were to be offered emergency appointments.

Where patients were experiencing poor mental health the practice worked with a local mental health trust on their case management. Patients who were identified as suffering from poor psychological health could be referred to the Improving Access to Psychological Therapies (IAPT) service and a local counselling service.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, a survey of patients undertaken by the practice's patient participation group (PPG) and feedback from patients who completed 'friends and family' comment cards. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was rated 'among the best' for patients who rated it highly for being listened to by their GP and finding receptionists at the practice helpful. Eighty per cent of patients who responded to the national patient survey said that they would recommend the practice.

We also spoke with two patients on the day of our inspection who told us they were satisfied with the care provided and said their dignity and privacy was respected. They commented that they were happy with the level of care they received from the practice. 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. Patients told us that they had been supported and assisted to make informed decisions about their health and future treatment plans.

We received 16 completed CQC comment cards and the majority were positive about the service experienced and aligned with these views. Patients said they felt the practice offered an excellent service and all staff were helpful, friendly and caring. Specifically, patients felt that reception staff were professional and friendly.

Patients were generally satisfied with the appointments system. Seventy nine per cent of patients who completed the national patient survey responded positively when asked how easy it was to get through to the practice by phone and that they could see a doctor on the same day if they needed to. The results from the comment cards received from patients showed that overall, patients in urgent need of treatment had often been able to make an appointment on the same day by contacting the practice. A small number of patients commented that it could take a long time to get an appointment and book in advance.

The practice had recently initiated the NHS Friends and Family Test (FFT). This is an opportunity for patients to provide feedback on NHS services including hospitals and GP practices. FFT comment cards were available in the reception area for patients to complete and give their feedback. We looked at feedback from ten patients. Overall the comments were positive, patients said that the practice provided a good service and staff were helpful and friendly and listened to them.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff are aware of the chaperone policy and the role of the chaperone and ensure training is provided to members of staff who undertake a formal chaperone role.
- A training and development plan should be put in place for new staff to ensure they are aware of their responsibilities and have the appropriate competencies for child protection.
- Provide detailed awareness training for all staff on safeguarding adults at risk.
- Ensure audit cycles are completed to drive continual improvement.

Pitshanger Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and included a GP specialist advisor. The GP specialist advisor was granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Pitshanger Family Practice

Pitshanger Family Practice is located in a residential area of Ealing and provides a general practice service to around 3,000 patients. The practice has a higher than average number of patients aged between 25 – 44 years and provided for an average number of patients who were children and older people. The practice was situated in an affluent area of central Ealing which had a low transient population group. We were informed by staff that patients at the practice were predominantly white British. The practice reported low levels of disadvantage and social vulnerability within their patient group.

The practice is registered to carry on the following regulated activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Surgical procedures; and Treatment of disease, disorder or injury.

The practice team comprises of four GPs, a practice manager, two practice nurses, a health care assistant, phlebotomist and three receptionists/administrators. There are two GP partners, one male and one female and two female salaried GPs. One of the salaried GPs had recently joined the practice to cover maternity leave. The practice nurses are employed on a permanent locum contract and are both female.

The practice has a General Medical Services (GMS) contract with NHS England. The practice is open between 07.30am and 17.30pm on Monday, 08.30am and 17.30pm Tuesday and Friday, 08.30am and 18.00pm on Wednesday and 8.00am and 19.30pm on Thursday.

Appointments and telephone consultations are available 7:30 -12.30 and 14.30-17.30 on Monday, 08.30-12.30 and 2.30 -17.30 on Tuesday, 8:30 -12.30 and 15.00 – 17:30 Wednesday, 08:00 -12:30 and 16:00 to 19:00 on Thursday and 8:30-12:30 and 14:00 – 17:00 on Friday.

The practice holds three weekly clinics which are phlebotomy (taking bloods) on Monday between 07:30 and 11:30, a blood pressure clinic on Wednesday between 14.00 and 16:30 and INR monitoring (a test used to monitor the effects of the medicine warfarin) on Wednesday between 14:00 and 16:00. The INR clinic is run by the Healthcare Assistant; this also includes home visits if this is required.

The practice have opted out of providing out-of-hours services to their own patients. The practice had an out-of-hours provider the details of which were on the practice website. When the practice is closed patients are also directed to the 111 telephone service or the urgent care centre at Ealing Hospital which is open twenty four hours a day. Patients were able to book appointments and request repeat prescriptions online via the practice website.

There were no previous performance issues or concerns about this practice prior to our inspection.

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

Detailed findings

of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 January 2015. During our visit we spoke with a range of staff including GPs, nurses and reception staff, and spoke with patients who used the service. We reviewed the treatment records of patients. We reviewed comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. We saw that learning points from incidents and complaints were recorded and the practice reviewed these periodically to ensure there had not been a recurrence. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these. An example of this was ensuring only practice nurses were responsible for giving childhood immunisations as a result of a significant event. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email to clinical staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

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 child protection. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. A safeguarding flow chart

was on display which gave staff guidance on how to report a safeguarding concern. Key contacts and telephone numbers for reporting were listed. Staff had access to safeguarding protocols which were kept in the reception area.

The practice had a dedicated GP as lead in safeguarding vulnerable adults and children. Clinical staff had received training in child protection training to Level 3, with the exception of a practice nurse who had recently joined the practice had not undertaken this training. Non clinical staff had received child protection training to Level 1.

The practice had a safeguarding adult's policy which outlined the different types of abuse and how staff should respond. We saw from training records that not all staff had received formal training in safeguarding adults; however staff we spoke with demonstrated an understanding and awareness of safeguarding and knew the appropriate reporting procedures. All staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The policy had identified clinical staff only as acting in the chaperone role. Although the majority of staff were aware of the policy, some staff we spoke with were unsure of who should act as a chaperone. We saw that the chaperone policy had been reviewed in a staff meeting in 2013. There was no formal training for staff acting as chaperone.

The practice had a system for identifying children and young people with a high number of Accident and Emergency attendances. The Clinical Commissioning Group (CCG) provided practices in the area with a quarterly accident and emergency frequent attendees list for children and adults. A spreadsheet was kept by the practice listing frequent attendees to accident and emergency and the action that had been taken by the practice if this was required. The practice followed up children who

Are services safe?

persistently failed to attend appointments. We saw documentary evidence of letters and texts which had been sent to patients/parents requesting the reason why appointments had not been attended.

Medicines management

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

Processes were in place to check medicines monthly to ensure they were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The temperature of the fridge used for storing vaccines was recorded daily and documentation confirmed that temperatures remained in the required range. The practice did not keep controlled drugs on the premises.

The nurses administered vaccines using Patient Group Directions (these are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) which had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked two anonymised patient records which confirmed that the procedure was being followed.

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. A repeat prescribing protocol was in place for repeat prescriptions.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place which covered

daily, weekly and monthly cleaning tasks and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager was the lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw from records that the infection control lead had carried out cleaning 'spot checks' in April and October 2014 and January 2015. We also saw the inspection report of an infection control audit which had been carried out by NHS North and East London Commissioning Support Unit on 6 November 2014. At our inspection we noted some areas for improvement identified by the audit, had been addressed by the practice. We were informed by the lead that a follow up infection control audit had been announced for 9 January 2015. As this was three days after our inspection we requested and were sent the inspection report for the follow up infection control audit. The report concluded that the majority of improvements had been made and the practice was now compliant with infection prevention and control guidelines.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records to confirm that a water flow risk assessment had been carried out by an external contractor on 22 January 2013.

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. A contract was in place for testing medical equipment and all

Are services safe?

portable electrical equipment had been tested in 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, thermometers, and ultrasound handsets.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example we looked at recruitment records of two members of clinical staff one of whom had recently joined the practice. Proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) were available for inspection. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw evidence this had been followed in the staff files we reviewed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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. The practice had carried out a fire risk assessment in February 2013 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training which had been discussed at staff meetings. We saw records to confirm that fire equipment and fire alarms had been serviced in January 2014.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were

discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from the infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example we saw that the practice used an assessment tool to identify patients in this group who may be at risk of deteriorating mental capacity.

There were emergency procedures in place for patients with long term conditions and acute pregnancy conditions. Staff we spoke with were able to give examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Clinical staff were aware of the procedure to be followed and had access to patients case workers, community psychiatric nurses and the crisis team at a local psychiatric hospital. We saw an example of an alert on the electronic patient record informing reception staff that selected patients at risk of deteriorating mental health were to be offered emergency appointments.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We were informed that staff were trained to use the defibrillator as part of their basic life support training.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Are services safe?

the practice. Each risk was rated and mitigating actions recorded to reduce or manage risk. Risks identified included power failure, unplanned sickness and how the practice would respond to pandemic influenza.

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). We saw that a clinical audit on Chronic Obstructive Pulmonary Disease (COPD) had taken place against NICE guidelines. This was a first cycle audit with well defined standards. Patient records had been reviewed against these standards and agreed actions had been documented where these standards had not been met.

Clinical guidelines were received by the practice manager and forwarded to GPs and nurses. This also applied to Medicines and Healthcare Products Regulatory Agency (MHRA) safety alerts which were printed and given to GPs and nurses. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral. We saw referral review audits which had been undertaken by the GPs at the practice to ensure that patient referrals were taking place effectively.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included

data input, scheduling clinical reviews, and managing child protection alerts and medicines management. One of the GPs was the lead for minor surgery which was solely for the purpose of administering joint injections.

The practice had a system for undertaking clinical audits. The practice showed us four clinical audits that had been undertaken in the last three years. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. Following an audit of statins (a group of cholesterol lowering medicines) GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice in line with the guidelines.

A cancer referral audit was carried out in 2014. Patient records were audited to examine the number of patients who presented with symptoms and how quickly the referral was made to a cancer specialist. The purpose of the audit was to look at the time it took from the first point of contact with the GP to diagnosis.

The results of the audit indicated that overall there were no avoidable delays for the patient from GP consultation to diagnosis.

However, we did not see any evidence of completed audit cycles for the audits shown to us.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice had achieved 87% of their QOF points out of a target of 100. For example, 75% of patients with diabetes had received a foot examination within the last twelve months. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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

Are services effective?

(for example, treatment is effective)

by their 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 patient electronic recording system flagged up the 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.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice provided direct enhanced services for patients diagnosed with dementia. The practice had a register of patients with dementia; a code identified these patients in the electronic patient records.

Unplanned admissions to the accident and emergency department had been monitored and recorded. Patients who had an unplanned admission to hospital were monitored and invited in to the practice for a 30 minute consultation with a GP. A care plan was developed with the patient, the patient kept a copy of this and a copy was also kept in the patient record.

Post discharge procedures were in place and the practice nurses provided post hospital discharge services such as wound care and the renewal of dressings.

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

Staff meeting minutes evidenced that clinical outcomes for patients were discussed in staff meetings. An example of this was a review of children and young adults between the age of ten and eighteen who did not have a complete MMR

immunisation record. As a result of this review patients who were identified received a phone call from the practice and were offered an appointment with the practice nurse to receive their immunisation.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. A member of the clinical team was due to go on maternity leave and a replacement to cover this leave had been employed on a short term contract. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. The practice has a training record and staff training development plan. All staff undertook annual appraisals that identified learning needs from which action plans were documented. We looked at a selection of staff appraisals and saw evidence that as a result of these staff had identified areas for skill development and training. For example the practice nurses were required to attend quarterly training sessions and training in contraception injections, wound management and elderly care had been identified as development needs. Our interviews with staff confirmed that the practice was proactive in providing training.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

A staff meeting for the whole practice team took place took place four times a year. The GP partners met once a week to discuss patient care and they met with salaried GPs at the practice on a monthly basis. Staff had their areas of responsibility for example one member of the administrative staff was responsible for scanning documents and assisting patients with Choose and Book (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). Another administrator registered new patients and coded existing patients according to their condition. All staff had received training in information governance. Staff had access to key policies and procedures in the staff handbook which was

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issued to new staff. The GPs initiate warfarin therapy and an INR clinic was run by the Healthcare Assistant on Wednesday morning, this also includes home visits if this is required.

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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice undertook a yearly audit of the records of patients who required additional care on discharge from hospital to ensure their care had been managed appropriately. The practice held multidisciplinary team meetings to discuss the needs of complex patients. Patients on the palliative care register were reviewed once every three months with a palliative care nurse from a local service.

Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. Clinical governance meetings took place weekly between GPs and the practice manager.

Information sharing

New patients had their health records from the previous GP scanned onto their electronic record. A member of the administrative team was responsible for this work. The practice had electronic systems to communicate with other providers. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. The practice had also signed up to the electronic Summary Care Record and planned to

have this fully operational during 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). We saw that the introduction of summary care records had been discussed at a staff meeting and a decision made to display information on what this meant for the patient, in the reception area.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified. All staff had received training in information governance.

The practice had a system in place to manage test results. Pathology results were emailed direct to the named GP for his or her attention. In the event of further action being required the GP would send a 'task' to reception staff to contact the patient to make a follow up appointment. Reception staff informed us that there was a 48 hour timescale from receiving results to contacting patients when this was required. There were also daily procedures in place to check incoming electronic mail, for example patient contact information from the out of hours provider. When this information was received it was forwarded to the named GP.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw that the practice used an assessment tool to assess patients who may be at risk of diminished mental capacity.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and

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(for example, treatment is effective)

decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

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

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse or health care assistant to all new patients registering with the practice. The GP was informed of all health concerns detected at the initial health check and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 10% of patients in this age group took up the offer of the health check. The practice said the uptake of health checks was low although they had originally written to and texted eligible patients. We were informed that health checks were often opportunistic and carried out with patients consent during an appointment. The practice referred patients to the local pharmacist for smoking cessation where two of the pharmacists offered smoking cessation treatment.

A register was kept of patients who were identified as being at high risk of an unplanned admission to hospital. Records indicated that there was provision of a named GP for patients over the age of 75. Fifty five per cent of people over the age of 65 had received the seasonal flu vaccination. The autumn newsletter reminded patients of the benefits of the influenza vaccination and informed patients this would be available the practice from September 2014. The practice kept a register of patients with dementia, of these 82% had received a face to face review of their care within the preceding twelve months.

Patients with long term conditions had structured annual reviews. We saw evidence in patient records that advice on

health promotion, lifestyle advice and alcohol and smoking cessation had been documented. The practice used a medical assessment tool to identify patients at risk of long term conditions.

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. We saw from records that a small number of patients were on the register; these patients had a care plan and were offered an annual physical health check.

The practice's performance for cervical smear uptake 79% which was in line the CCG area which was 81%. There was a policy to write to patients who did not attend for cervical smears. There was also a named nurse responsible for following up patients who did not attend health screening. Patients who required sexual health screening, for example for chlamydia, were referred to a local sexual health clinic where these services were available.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Immunisation rates for all standard immunisations (e.g. DPPT, MMR and Rotavirus vaccine) were in line with the CCG average. Ninety seven per cent of children of children had received their booster vaccinations.

Children and young adults between the age of ten and eighteen who did not have a complete MMR immunisation record were followed up by the practice and offered an appointment with the practice nurse to receive their immunisation.

Information for patients on looking after their health was included in the practice newsletter which was issued four times a year. An example of this was contained in the most recent newsletter. This contained information on bowel cancer and the local bowel screening service, advice on the whooping cough vaccination for pregnant women, and a Department of Health update on childhood immunisations.

Where patients were experiencing poor mental health the practice worked with a local mental health trust on their case management. Eighty seven per cent of patients with a diagnosis of mental illness had a documented agreed care

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(for example, treatment is effective)

plain in their record. Patients who were identified as suffering from poor psychological health could be referred to the Improving Access to Psychological Therapies service and a local counselling service.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014, a survey of patients undertaken by the practice's patient participation group (PPG) and feedback from patients who completed 'friends and family' comment cards. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated it highly for being listened to by their GP and finding receptionists at the practice helpful. Ninety one per cent of respondents to the national patient survey said the last GP they spoke to was good at listening to them, exceeding the Ealing CCG average for this response of 55%. Eighty nine per cent of patients found the receptionists at the practice helpful in comparison to 83% of the Ealing CCG average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and all staff were helpful, friendly and caring. Specifically, patients felt that reception staff were professional and friendly. They said staff treated them with dignity and respect. We also spoke with two patients on the day of our inspection who told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. As a result of feedback from patients who had informed the practice the room was not totally 'sound proof' the consultation room on the ground floor adjacent to the

reception area was only being used for two sessions a week. Furthermore, we were advised at the time of the inspection the practice was procuring quotes for soundproofing the room.

We observed reception staff talk respectfully to patients and trying to accommodate their requests. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed 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 75% of practice respondents said the GP involved them in care decisions and 81% felt the GP was good at explaining treatment and results.

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. Patients told us that they had been supported and assisted to make informed decisions about their health and future treatment plans. One of the patients we spoke with gave an example of the information given to them on the referral to a secondary health service and an explanation of the medical procedure to be undertaken.

Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

Are services caring?

The practice had recently initiated the NHS Friends and Family Test (FFT). This is an opportunity for patients to provide feedback on NHS services including hospitals and GP practices. FFT comment cards were available in the reception area for patients to complete and give their feedback. We looked at feedback from ten patients. Overall the comments were positive, patients said that the practice provided a good service and staff were helpful and friendly and listened to them.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with survey information. For example, patients said that staff responded compassionately when they needed help and provided support when required. Eight four per cent of patients who responded to the national patient survey said the last GP they spoke with was good at treating them with care and concern and 81% said the last nurse they spoke to was good at treating them with care and concern.

Information on a local resource for patients with carer responsibilities was on display in the waiting room and on the practice website. The practice had written to all patients known to them in this category with information on local resources and support groups for carers.

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. Examples of this were how to request a chaperone, obtain a repeat prescription and test results.

Staff informed us that if families had suffered bereavement, their usual GP contacted them. Staff were able to refer bereaved patients to the CRUISE bereavement service in West London. Although we did not receive feedback on bereavement services we received information from patients which informed us GPs had been emotionally supportive during a difficult period.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). As a result of feedback from patients the practice now offered some appointments outside of normal working hours.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services. The practice provided equality and diversity training. The majority of practice staff had received 'skills for care' training in disability and diversity in 2012 and 2013. The premises and services had been adapted to meet the needs of patients with disabilities. Facilities for patients and consultation rooms and the toilet were situated on the ground floor and the toilet was accessible for patients with a disability. Patients were able to choose between a male or a female GP for their consultation.

Access to the service

Appointments and telephone consultations were available at 7:30 -12.30 and 14.30-17.30 on Monday, 08.30-12.30 and 2.30 -17.30 on Tuesday, 8:30 and 12.30 and 15.00 – 17:30 Wednesday, 08:00 -12:30 and 16:00 and 19:00 on Thursday and 8:30-12:30 and 14:00 – 17:00 on Friday.

In response to the practice patient survey where patients had requested out of working hours appointments, extended opening hours were available on Monday morning with the first available appointment with a GP or practice nurse at 7:30am. The practice also offered extended hours on Thursday with the last appointment at 19:00.

We saw evidence that an adjustment had been made to offer patients with a mental health diagnosis later appointment sessions in the day to enable them to make their way to the practice at a suitable pace and time. People experiencing poor mental health were offered flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may have found this stressful.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were planned between the hours 12:00 and 14:00 when required.

The practice had recently participated in a pilot scheme with other practices and opened every third Sunday for all patients within the central Ealing network of practices. The pilot was eventually evaluated by Ealing CCG and a decision made to discontinue Sunday opening at the practice due to the low uptake of appointments.

As result of the practice patient survey it was ascertained that 73% of patients were not aware that they could request a telephone consultation with a GP. Reception staff were prompted to remind patients of this option and information on telephone consultations was printed on patient prescriptions. An online appointment booking with text messaging service was available. We saw that patients had been given information the availability and use of the system in a newsletter.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were generally satisfied with the appointments system. Seventy nine per cent of patients who completed the GP Patient Survey responded positively when asked how easy it was to get through to the practice by phone and that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Are services responsive to people's needs?

(for example, to feedback?)

Comments received from patients showed those patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice, although a small number of patients commented that it could take a long time to get an appointment and book in advance.

The practice used an out of hours provider whose contact details were available on the practice website and telephone answering service. Patients we spoke with confirmed they had been able to obtain an emergency appointment when they needed one.

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. The practice manager was the responsible person for managing complaints at the practice. The complaints procedure contained information on the practice staff responsible for reviewing and responding to complaints, the time scale for investigation and external agencies who would review complaints about the practice.

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

The minutes of staff meetings evidenced that complaints were reviewed and learning points were identified and the practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. For example, as the result of a complaint the protocol for referring patients to secondary health service was reviewed and amended. Referral records were then checked by the practice approximately two months later to ensure the correct referral procedures were being followed.

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 safe, high quality services, providing excellence at all times and to work in partnership with other agencies to improve outcomes for patients. We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop computers at the practice. We reviewed a number of policies, for example the safeguarding policy, chaperone policy and the recruitment policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

There was a clear leadership structure with named members of staff in lead roles. GPs had lead roles for example in safeguarding, infection control and Caldicott Guardian. (A Caldicott Guardian is a person responsible for ensuring the safe keeping and appropriate use of information). We spoke with five members of staff and they were all clear about their own roles and responsibilities within the practice. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice nurse told us about a local peer review system 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 practices had presented case studies on supporting patients with diabetes and how to support those who found it difficult to adhere to diabetes management advice.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify

where action should be taken. The practice had audited information on medicines management, cancer referrals, the management of COPD and inadequate cervical smear test results.

Monthly governance meetings between held between the GP partners and the practice manager. The two GP partners and the two salaried GPs met every three months to discuss the management of the practice and patient care.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the safeguarding policy, chaperone policy and the recruitment policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey in conducted in conjunction with the PPG in 2014. As a result of survey feedback, arrangements had been made to sound proof a consultation room and only conduct a limited amount of consultations in this room which was close to the reception area. Patients had also requested an on line appointment booking system and this had been introduced with the new patient electronic recording system. We saw that patients had been informed of this new electronic recording system and how to use the on line booking facility in the Autumn newsletter.

The practice had an active PPG. We were informed that due to patient commitments members of this group did not meet in person but communicated by email. Two newsletters were produced annually and an annual patient survey was sent to patients. Information on the PPG and agreed actions for improvements were included in the newsletters. The PPG had carried out a survey in January and February 2014. The practice manager showed us the analysis of the last patient survey, which was available on the practice website.

Management lead through learning and improvement

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 the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

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. The way the practice managed some aspects of patient care had been improved in response to incidents and complaints.