Dr P Kumar & Partners

Quality Report

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Date of inspection visit: 27 May 2015
Date of publication: 01/10/2015

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	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 Dr P Kumar & Partners (also known as Chessington Park Surgery) on 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services to Older people, Working age people (including those recently retired and students), Families, children and young people, People whose circumstances may make them vulnerable, and People experiencing poor mental health (including people with dementia). Chessington Park Surgery is rated as outstanding for the care of people with long term conditions.

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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw the following areas of outstanding practice:

Summary of findings

- The practice provided a range of additional services and support in-house to people with long term conditions including diabetic retinal screening, dietician, podiatry and an expert patient programme. A care coordinator was in post to coordinate the care of patients with long term conditions.
- The practice proactively sought and built relationships with other local providers for the benefit of their patients. They hosted various organisations in their practice premises including the local carers' network on a fortnightly basis, and a six session community based programme for people with long term conditions, called expert patient programme. The expert patient programme had been completed by three patients from Chessington park surgery during April 2015.
- In November 2014, the practice used a secret shopper service to assess the effectiveness of their chlamydia screening programme. They used the feedback of the 'shopper's' experience to plan improvements which included briefing to the reception team by the practice nurse, who had specialist training in sexual health; and provided a separate area that the reception staff could take patients to discuss private matters.
- The practice arranged for students from a local learning disabilities school to visit the practice over a lunchtime period when they when they were quiet, to spend time with the staff team, learn more about what they do, and to help reduce any fears they may have about visiting their doctor surgery. The session was well received by the teachers and students.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed a patient-centred culture. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice had a named accountable GP for all people aged 75 and over, who was responsible for overseeing their care. Patients with more complex health care needs were risk assessed and had personalised care plans. Their needs are reviewed regularly as per the Avoidable Unplanned Admission (AUA) guidelines by a named care coordinator who also liaised with the named GP after any admissions for review and any update of their care plan.

Longer appointments were available for patients who had that need, and home visits were available for any housebound patients.

Annual flu vaccination was offered to patients over the age of 65 annually, and data showed that for the winter of 2013 / 14, the practice provided 71% of its patients in this age group, which was similar to the national average.

The practice clinical team met with district nurses every Friday to discuss the shared care of any patients, and any housebound patients. The community matron attends the Friday meeting as and when it is relevant. The practice also worked closely with the local integrated care team and rapid response team to manage urgent health and social care needs in order to avoid any hospital unnecessary admissions. Once every six months there was a multi-disciplinary team meeting at the practice to improve communication and discuss any changes.

People with long term conditions

Outstanding

The practice is rated as outstanding 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.

All patients with long term conditions such as diabetes, chronic heart disease (CHD), chronic obstructive pulmonary disease (COPD), asthma, and dementia are on the practice disease registers.

Summary of findings

The practice had a care coordinator who organised annual health checks and reviews for patients with long term conditions. The practice had a nurse practitioner who reviewed all the COPD patients and performed their spirometry tests as part of their winter care plan, which was agreed in collaboration with their lead GP.

The practice's diabetic nurse reviewed the diabetic patients in collaboration of a lead diabetic GP and the care of these patients were managed with an agreed care plan. The practice was able to initiate and manage insulin therapy. The practice offered in-house diabetic retinotherapy screening service (DRSS) for all diabetic patients.

There were in-house dietician and podiatry services. Diabetic and COPD patients were given 20 minute appointments for their review. Housebound patients were managed by the community matron and district nursing team in close collaboration with the GPs. The practice nurse also reviewed CHD patients annually.

The practice had an in-house Expert Patient Programme for its patients with long term conditions. Through the programme, patients attended regular meetings were they were able to meet, support each other and share their experiences and coping mechanisms with other patients experiencing similar conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Immunisation rates were relatively high for all standard childhood immunisations. The practice hosted weekly baby clinics and immunisation clinics in collaboration with health visitors and a lead GP.

Appointments were available outside of school hours and the premises were suitable for children and babies.

We saw that the practice had arrangements for joint working with midwives and health visitors. The practice provided ante-natal and post-natal care to our patients with 20 minute appointments. Once a week there is a midwife led ante-natal clinic. There is Safeguarding GP Lead for children who is aware of all vulnerable children and reviews their care in liaison with health visitors and social services.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice provided two extended hours clinics every week from 6.30 pm to 8.00pm to cater for commuters. Once every fortnight, they also provided a Saturday morning clinic from 8.30am to 10.30am for working age groups.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 people with dementia and those with a learning disability.

It had carried out annual health checks for people with a learning disability. There were 12 patients on its learning disabilities register and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people, and provided information to the about 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. All staff have received training for safeguarding children and vulnerable adults. The practice had appointed a lead GP for safeguarding.

The practice had three female GPs and two male GPs, so patients were able to see same sex clinicians if that was their preference.

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). QoF data for the year ending 31 March 2015 showed that the practice had

achieved 100% for all the clinical indicators relating to the care of people experiencing poor mental health. These indicators included checks on their physical health and that those eligible were on the appropriate medications.

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.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice had a register of patients with severe mental health and dementia who had annual health checks with a lead GP. The annual checks included a review and update their care plan. These patients were also under the care of the mental health team in the hospital for review of their condition and any change in their care plan was reviewed by the lead GP.

Patients experiencing poor mental health were given 20 minute appointments to support them in discussing any issues appropriately.

Summary of findings

What people who use the service say

We received 13 CQC comment cards from patients, which were completed in the two weeks leading up to the inspection and on the inspection day itself. Eleven of the comments cards were entirely positive, with patients saying they received a consistently good service, felt well cared for, and that the staff team were helpful and attentive to their needs. Two of the comments cards also included less positive comments which related to the attitude of the reception staff and difficulty getting appointments.

We spoke with three patients during our inspection. They all commented positively about their care and treatment experiences, and the quality of the clinical care they received.

The practice had also received positive feedback from its patients through the friends and family test.

We spoke with two members of the practice Patient Participation Group (PPG). They told us they enjoyed a good working relationship with the practice staff team, and that they felt supported in promoting the PPG's agenda and priorities. They told us they found the practice team open and transparent, and listened and responded to their feedback.

Data from the 2014 national GP patient survey showed that the practice performed well against the local average in terms of the quality of their GP consultations. For example, 83.7% of respondents said the last GP they saw or spoke to was good at treating them with care and concern, whilst the local area and national averages were 83.7% and 85.1% respectively; 92.1% of respondents said the last GP they saw or spoke to was good at listening to them, the local and national averages were 88% and 88.6% respectively; and 84.7% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments, the local average and national averages were 84.9% and 86.3% respectively.

Data from the 2014 national GP patient survey also showed that the practice performance was better than the local area and national averages in terms of overall patient experience and satisfaction: 86.4% of respondents described their overall experience of this surgery as good; the local and national results for this question were 83.3% and 85.2% respectively. However, 70.9% would definitely or probably recommend the surgery to someone new to the area; the local and national results were 75.5% and 78% respectively.

Outstanding practice

We saw the following areas of outstanding practice:

- The practice provided a range of additional services and support in-house to people with long term conditions including diabetic retinal screening, dietician, podiatry and an expert patient programme. A care coordinator was in post to coordinate the care of patients with long term conditions.
- The practice proactively sought and built relationships with other local providers for the benefit of their patients. They hosted various organisations in their practice premises including the local carers' network on a fortnightly basis, and a six session community based programme for people with long term conditions, called expert patient programme. The expert patient programme had been completed by three patients from Chessington park surgery during April 2015.
- In November 2014, the practice used a secret shopper service to assess the effectiveness of their chlamydia screening programme. They used the feedback of the 'shopper's' experience to plan improvements which included briefing to the reception team by the practice nurse, who had specialist training in sexual health; and provided a separate area that the reception staff could take patients to discuss private matters.
- The practice arranged for students from a local learning disabilities school to visit the practice over a lunchtime period when they when they were quiet, to

spend time with the staff team, learn more about what they do, and to help reduce any fears they may have about visiting their doctor surgery. The session was well received by the teachers and students.

Dr P Kumar & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The other inspection team member was a GP specialist advisor. They are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr P Kumar & Partners

Dr P Kumar & Partners (also known as Chessington Park Surgery) is located in Chessington, a suburb in South West London bordering Surrey. The practice had approximately 6300 patients at the time of our inspection.

Chessington Park Surgery is located within purpose built premises, Merritt Medical Centre, which it shares with another GP practice and a pharmacy.

The practice clinical staff team are two male GP partners, three salaried GPs, a nurse practitioner, a practice nurse, and a healthcare assistant. The nursing team were all female. The administrative team are a practice manager, an assistant practice manager, an office manager, and a team of reception and administrative staff. The practice also employs a care taker jointly with the other GP practice in Merritt Medical Centre.

Chessington Park Surgery became a training practice in 2014. A training practice provides placements to GP trainees and F2 doctor). The practice has a personal medical services (PMS) contract for the provision of its general practice services.

Chessington Park Surgery is registered with the Care Quality Commission (CQC) to carry on the regulated activities of Diagnostic and screening procedures; Treatment of disease, disorder or injury; Maternity and midwifery services; Family planning services; and Surgical procedures to everyone in the population. These regulated activities are provided from the practice site at Merritt Medical Centre. Merritt Gardens. Chessington. Surrey. KT9 2GY

The practice is open from 08.00am to 1.00pm, then 2.00pm to 6.30pm on Mondays, Tuesdays and Fridays; and open from 08.00am to 1pm, then 2.00pm to 8.00pm on Wednesdays and Thursdays. Appointments are available from 08.30am to 1.00pm, then 2.00pm to 6.00pm on Mondays, Tuesdays and Fridays; and from 08.30am to 1.00pm, then 2.00pm to 8.00pm on Wednesdays and Thursdays. Extended hours surgeries are offered between 6.30pm and 8pm on Wednesdays and Thursdays, and every other Saturday morning.

When the practice is closed, patients are asked to contact the 111 telephone service where they will be put through to the practice's out of hours provider. The practice contracts Care UK to provide out-of-hours services to their own patients.

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.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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 27 May 2015.

During our visit we spoke with a range of staff (GPs, nurses, healthcare assistant, practice management, reception and administrative staff) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed in the last 12 months prior to our inspection. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of nine significant events that had occurred during the 12 months prior to our inspection and saw this system was followed appropriately. Significant events was a standing item on the practice clinical meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms available on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked an incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, following an incident where a patient who was prescribed methotrexate had not received the appropriate review, the practice team was updated on the need to ensure such patients are booked for blood test reviews after the medicine had been issued to them a maximum of three times. The process for reviewing blood tests was also amended to ensure the clinician ordering the test was the one allocated to review the result, except if they were away in which case the senior partner was allocated the results to review.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were received electronically through an online resource the clinical team were signed up to. The clinical team were able to acknowledge they had received the alerts, and they discussed them at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, such as a recent alert relating to asthma FENO testing.

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. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff, who had received appropriate training, would act as a chaperone if nursing staff were not available and understood their responsibilities, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

For vulnerable patients, the practice had a system for identifying children and young people with a high number of emergency department attendances.

The practice clinical team provided reports for child protection case conferences and reviews. There was a system in place to follow up children who persistently failed to attend appointments, such as for childhood immunisations.

For older people/families, children and young people, vulnerable people, the practice had a system to highlight vulnerable patients. There was also a system for reviewing repeat medications for patients with co-morbidities/ multiple medications

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by a clinician with an appropriate level of authority. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD.

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. Colour coded cleaning activity sheets were displayed in the cleaning materials cupboard so they readily had information about what areas and at what frequency they were to be cleaned.

The practice organised weekly thorough cleaning of the nurses rooms and minor surgery unit, and three monthly deep cleaning of the premises

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection prevention and control (IPC) who had undertaken further training for the role. The IPC lead undertook regular audits within the practice. We saw the report of a recent handwashing audit they had completed, and a general IPC audit carried out on 10 April 2015. All staff received induction training about infection control specific to their role and received annual updates.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment for legionella in November 2013, and the next assessment was due in November 2015.

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 such as weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer which was completed in October 2014.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). All staff employed in the practice had received DBS checks prior to their employment.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice had also completed audits of patient needs for appointments and used the results to inform their clinical and administrative staffing levels.

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 met 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy, and completed annual health and safety audits. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Good

Are services safe?

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 in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was reviewed annually and was last updated in April 2015.

The practice had carried out annual fire risk assessments that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they carried out weekly fire alarm testing.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

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

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

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the nursing team supported this work.

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

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last year: one was on the care of patients with asthma and the second was on the prescribing of newer hypoglycaemic to diabetic patients. The asthma audit was a completed audit where the practice was able to demonstrate improvements in the review, health education and prescribing of recommended medicines among the patient group. The first cycle of the audit of prescribing for diabetic patients was carried out in March 2015. Action points that followed included ensuring patients were provided the recommended reviews and prescribed medicines. The second cycle was due to be repeated in March 2016. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It

Good

Are services effective?

(for example, treatment is effective)

achieved 100% of the total available points for the year ending 31 March 2014, which was above the local area and national average. This was demonstrated by their achievement of maximum scores for indicators relating to asthma, cancer, chronic kidney disease, dementia, heart failure as well as other long term conditions.

The practice exception reporting rate was also below the local area and national averages.

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.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support.

We noted a good skill mix among the doctors with additional diplomas achieved among them including child health, urology, dementia care, dermatology and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing and supporting training and development for their roles.

Chessington Park Surgery was accredited as a training practice in 2014, and now accepts doctors who were training to be qualified as GPs for placements as part of their training.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and carrying out cervical screening. Those with extended roles such as in monitoring and reviewing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP partner on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were relatively low and similar to expected when compared with the national average. The practice was commissioned for the unplanned admissions avoidance 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). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held quarterly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, and those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Good

Are services effective?

(for example, treatment is effective)

The practice also held weekly meetings with their district nurse to discuss the care of patients whose care was shared among their teams.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice used a shared clinical service, Coordinate My Care, which allows healthcare professionals to record patients' wishes and ensures their personalised care plan is available to all those who care for them.

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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff followed the principles of the MCA, and involved appropriate decision makers in agreeing best interest decisions about their care and treatment.

There was a practice policy for documenting consent for specific interventions. For example, consent was sought prior to the administering of immunisations, and was documented in the patient record.

Health promotion and prevention

The practice had a dedicated patient resource room adjacent to the waiting area. The resource room had a range of health promotion leaflets and posters, a blood pressure machine and weighing scales that patients were free to use. The resource room was also used to host events at the practice, such as Carers meetings.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. During the year ending 31 March 2015, 19 patients had been screened for chlamydia in the at-risk age group, and the practice had 805 patients in the at risk age group.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 609 of patients in this age group took up the offer of the health check in the last five years. The practice had a process for following up patients if they had risk factors for disease identified at the health check and further investigations were scheduled for them.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had actively offered nurse-led smoking cessation clinics to 99.89% of its patients over the age of 16 who had identified themselves as smokers. Since 01 April 2014, 133 patients had successfully completed a smoking cessation programme.

The practice's performance for the cervical screening programme for the year ending 31 March 2015 was 81%, which was at the national average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 71%, and at risk groups 51%. These were similar to national averages.

Childhood immunisation rates for the vaccinations recommended at 12 months and 24 months of age ranged from 75.7% to 95%, and for five year olds from 91.9% to 100%. These were comparable to the CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published on 08 January 2015, and the results of the friends and family test.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national GP patient survey showed that the practice was scored similar to or above the local area and national averages for its satisfaction scores on consultations with doctors. For example:

- 92.1% said the GP was good at listening to them compared to the CCG average of 88% and national average of 88.6%.
- 89.1% said the GP gave them enough time compared to the CCG average of 84.7% and national average of 86.8%.
- 94.7% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.5% and national average of 95.3%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the majority were entirely positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments cards also contained slightly less positive feedback but there were no common themes to these.

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

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Confidential calls were directed to the admin back office to provide patients the necessary additional privacy. The results from the national GP patient survey showed that 86.6% of respondents found the receptionists at the practice helpful which was similar to the local area and national averages.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed 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:

- 84.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84.9% and national average of 86.3%.
- 77.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79.7% and national average of 81.5%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 83.7% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83.7% and national average of 85.1%.
- 96.7% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89.2% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient resource room and on the practice website told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There were 93 patients on the carers register at the time of our inspection. There was written information available for carers and the practice hosted support events for carers, to ensure they understood the various avenues of support available to them. Kingston Carers Network held one to one support sessions fortnightly at Chessington Park Surgery. These sessions have proved successful and were well attended. The practice invited the carers on a monthly basis to attend these sessions. Patients who were newly registered were also advised of these sessions.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. There was a noticeboard in the practice administration room with a section informing staff of recent bereavements.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example they provided a range of additional services for people with long term conditions including diabetic retinal screening, dietician, podiatry and an expert patient programme. A care coordinator was in post to coordinate the care of patients with long term conditions.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included the provision of additional telephone consultation slots during the day, increased staffing levels at the reception desk and the directing of confidential calls to the admin back office.

Patient feedback and complaints were also regularly discussed at staff meetings and improvement actions put in place.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, patients with multiple complex needs or those receiving health or medication reviews.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as there was lift access between the ground and upper level in the premises and disabled parking spaces close to the building. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams.

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

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Access to the service

The practice is open from 08.00am to 1.00pm, then 2.00pm to 6.30pm on Mondays, Tuesdays and Fridays; and open from 08.00am to 1pm, then 2.00pm to 8.00pm on Wednesdays and Thursdays. Appointments are available from 08.30am to 1.00pm, then 2.00pm to 6.00pm on Mondays, Tuesdays and Fridays; and from 08.30am to 1.00pm, then 2.00pm to 8.00pm on Wednesdays and Thursdays. Extended hours surgeries are offered between 6.30pm and 8pm on Wednesdays and Thursdays, and every other Saturday morning.

When the practice is closed, patients are asked to contact the 111 telephone service where they will be put through to the practice's out of hours provider. The practice contracts Care UK to provide out-of-hours services to their own patients.

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.

Longer appointments were also available for patients who had that need. This also included appointments with a named GP or nurse.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 74.4% were satisfied with the practice's opening hours compared to the CCG average of 72.8% and national average of 75.7%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 70.6% described their experience of making an appointment as good compared to the CCG average of 67.7% and national average of 73.8%.
- 78% said they could get through easily to the surgery by phone compared to the CCG average of 66.7% and national average of 74.4%
- However, 61.4% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68.5% and national average of 65.2%.

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

Listening and learning from concerns and complaints

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

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

We looked at the summaries of the complaints received in the year ending 31 March 2015. We found they were satisfactorily handled, dealt with in a timely way and that there was openness and transparency in dealing with complaints.

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 and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had recently become a training practice and the senior partner told us they were keen to develop their educational links and keep up their current high standards.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures and saw that processes were available to allow them to be shared electronically with the staff team, and for them to verify they had read them. All the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. The members of staff we spoke with during our inspection knew the lead colleagues for various aspects of the service, and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing better than the local area and national averages. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Examples of audits that the practice provided us details of during our inspection were one on the care of patients with asthma and a second on the prescribing of newer hypoglycaemic to diabetic patients.. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice held a range of meetings including practice, clinical, clinical forum, and multidisciplinary meetings. We looked at a sample of minutes from these meetings and found that performance, quality and risks had been discussed.

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

Leadership, openness and transparency

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

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had a PPG that met quarterly and included patients from the two GP practices on the premises.

Are services well-led?

Good

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

We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). They gave us examples of suggestions they had made that had been implemented by the practice, such as the provision of a blood pressure machine in the patient resource room.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff away, staff meetings, appraisals and discussions). Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at a sample of 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 had staff away days in the past where guest speakers and trainers attended.

The practice became a GP training practice in 2014.

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.