The Orchard 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Orchard Practice on 12 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 outstanding for providing services for patients with long term conditions and good for all the population groups including older people; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and 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 several areas of outstanding practice including:

Summary of findings

- The practice had implemented a monthly audiology clinic for hearing aid users (registered and non-registered patients) to have their hearing aids serviced and repaired. This helped local patients avoid long bus trips to the hospital.
- The healthcare assistant responsible for smoking cessation had won a CCG award for their work in smoking cessation and for two years running the practice had the second highest quit rate in the CCG.

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

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

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 National Institute for Health and Care Excellence and used it routinely. Patient's 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

GOOD

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

Are services responsive to people's needs?

Good

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

Summary of findings

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. 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

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

The advanced nurse practitioner in conjunction with community services undertook reviews for all housebound patients.

The practice worked with the Stay Well project to identify patients who required additional help at home before they reached a crisis stage. The practice routinely offered up to five patients a month the opportunity to be part of the Stay Well at Home service. These patients were identified by any member of the practice team, for example a receptionist who had noticed that a patient needed help collecting their prescriptions or a GP who felt that companionship and socialising might help improve a patient's health.

A monthly audiology clinic for hearing aid users was offered to have their aids serviced and repaired.

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.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions (LTCs). Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

The practice also provided Tier 3 diabetic clinics to patients with diabetes registered at the practice .(Tier 3 service consists of increased specialist diabetes support at general practices, alongside structured education to GPs and patients, and regular multidisciplinary (MDT) clinics at a range of sites in the area).

The practice had achieved 98% in the quality and outcomes framework (QOF) for the care of patients with long term conditions. The practice nurses also visited housebound diabetic patients at home. The practice also held specific monthly meetings to focus on LTCs.

Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For

Summary of findings

those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice also offered a weekly dossett box system, managed by a senior administrator to ensure accuracy of weekly prescribed medicines.

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. Patients told us that 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. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice also offered ante-natal classes run by a parenting specialist free of charge to all their patients.

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 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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% 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. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in

Summary of findings

vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).Ninety six percent of people experiencing poor mental health had received an annual physical health check. 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.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. They told us the staff who worked there were caring and understanding, and there were no problems getting appointments. They also told us they found the premises to be clean and tidy.

We reviewed ten CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided. The latest National GP Patient Survey completed in 2015 showed a fair number of patients were satisfied with the services the practice offered. There were 359 surveys sent out and 123 were returned. This was a 34 % completion rate. The results were that 70 % of patients said they would recommend the practice, compared to a national average of 85 %; 80 % of patients said they were 'fairly satisfied' or 'satisfied' with the opening hours, compared to the national average of 79 %; 69% of patients said that it was 'very easy' or 'easy' to get through on the phone, compared to the national average of 75 %.

Areas for improvement

Action the service MUST take to improve

N/A

Action the service SHOULD take to improve

N/A

Outstanding practice

N/A

The Orchard Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, a GP specialist advisor and a practice manager. They are granted the same authority to enter registered persons' premises as the CQC inspector.

Background to The Orchard Practice

The surgery is located in the London Borough of Kingston, and provides a general practice service to around 7,000 patients. Kingston Clinical Commissioning Group (CCG) is comprised of 26 member GP practices serving a population of approximately 190,000. The CCG covers the geographical area within the boundary of the Royal Borough of Kingston upon Thames.

On average, people in Kingston have a longer life expectancy than found in England or in London

The main ethnic minority groups in the borough are Indian/ British Indian (4%), Sri Lankan (2.5%), African (2.3%) and Korean (2.2%). The Indices of Deprivation rank Kingston upon Thames as the third least deprived local authority in London. The Orchard Surgery has a higher population of patients aged 65 and over.

The practice is located in a purpose built building. The current partners and management took over the practice in 2011.

The practice is registered as a partnership with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; family planning services; and maternity and midwifery services at one location.

The practice has a General Medical Services (GMS) contract and provides a full range of essential, additional and enhanced services including maternity services, child and adult immunisations, family planning, sexual health services and minor surgery. The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is currently from 7:30am-18:30pm Monday to Fridays. In addition, the practice offers extended opening hours until 20:00pm on Tuesdays and Thursdays. Consultations run all day from 07:30am. Telephone lines are open until the practice closes in the evenings. When the practice was closed, the telephone answering service directed patients to contact the out of hours provider.

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

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

Why we carried out this inspection

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

Detailed findings

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 12 May 2015. During our visit we spoke with a range of staff GPs, practice nurses, practice manager, healthcare assistants and administrative staff and spoke with ten patients who used the service. We observed how people were being cared for and talked with carers and family members and reviewed the personal care or treatment records of patients. We received ten completed comment cards where patients and members of the public shared their views and experiences of the service.

Good

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. Examples of reported incidents included clinical and administrative errors as well as near misses. The practice reported all serious adverse events that compromised patient safety to the National Reporting and Learning System (NRLS) as required.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. 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 significant event analysis (SEA) policy and procedures that staff followed. SEAs enable the practice to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care they provide. 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 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 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 three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example; the practice found that incidents relating to communication failures between the practice and the hospital were a common theme. As a result the practice changed the system for disseminating incoming post to the named or most relevant GP, rather than on a straightforward pro-rata basis. This enabled all communications to be dealt with appropriately and improved continuity of care.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were received on the practice generic email and were then forwarded to the most appropriate staff. However, alerts we followed through did not always show the conclusion of the necessary action the practice had taken. The practice manager and GPs as all confirmed that there was a designated GP for acting upon clinical alerts. We saw some examples where the clinical lead had acted on alerts, but the practice agreed that the system needed to be improved. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. Examples given were on alerts of medicines being withdrawn or changes in immunisation schedules. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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. The GPs and the nurses had completed Level 3 and 2 child protection training respectively. The nurses at the practice were due to undertake Level 3 child protection training. All administrative staff had completed Level 1 training. 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 GPs as leads in safeguarding vulnerable adults and children. They had been trained and

could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with knew who these leads were and who to speak within 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 had alerts on their clinical notes to ensure clinical staff we aware of any issues. The practice also worked with other health and social care organisations to identify children with a higher than normal accident and emergency attendance rate or unexplained injuries to detect abuse or neglect.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (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 would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All reception staff acting as chaperones had a criminal records check through the Disclosure and Barring Service (DBS).

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 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.

We saw records of practice clinical meetings that noted the actions taken in response to a review of prescribing data such as anti-biotic use. The practice had been awarded financial incentives for three years running by the local Clinical Commissioning Group (CCG) as part of their efficient savings on prescribing.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

The practice had health care assistants who administered some vaccines using patient specific directions (PSDs). PSDs are traditional written instructions, signed by a doctor or non-medical prescriber (hereafter referred to as "the prescriber") for medicines to be supplied and/or administered to a named patient after the prescriber had assessed the patient on an individual basis. We found that the health care assistants had received appropriate training to administer the vaccines.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The GP specialist advisor checked ten 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.

Cleanliness and infection control

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

The practice had a 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. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out

audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An up to date 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.

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 that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last check had been completed in January 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; for example weighing scales, spirometers, blood pressure measuring devices and the refrigerator thermometer. We saw evidence that calibration of all relevant equipment had been completed in August 2014.

Staffing and recruitment

Staff records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that the practice manager regularly liaised with the relevant authorising bodies to ensure that the GPs and nurses maintained their registration which allowed them to practice.

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. Newly appointed staff had this expectation written in their contracts.

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 also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

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 senior practice nurse had shared the recent findings from an infection control audit with the team.

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

Good

Are services safe?

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.

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 the practice. This had reviewed annually and was up to date. 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 practice had carried yearly fire risk assessments that included actions required to maintain fire safety. Records showed that staff was up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes both planned and unplanned were included on the practice risk log. The practice benefited from having another location and the risk assessments took account of this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had an appointed GP who was the clinical lead. They were responsible for ensuring that the practice staff accessed and applied all directives from the clinical commissioning group (CCG) and other relevant bodies.

All clinical staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of practice clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. Examples of guidance being used was on the care of patients with diabetes.

The GPs told us they led in specialist clinical areas such as diabetes, dermatology and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. 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 guidelines for the management of long term conditions such as diabetes. Our review of the clinical meeting minutes confirmed that this happened.

The practice had also completed a review of case notes for patients with diabetes which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

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 of patients with suspected cancers who were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The practice also used the significant event analysis (SEA) monitoring to ensure that any urgent referrals that had not met the required referral times were investigated.

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. The practice used an internal system to discuss all referrals as well as the CCG policies.

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. The practice used a nationally recognised diagnostic coding system. This enabled them to easily identify patients with long-term conditions and those with complex needs 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 six clinical audits that had been undertaken in the last two 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 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.)

We saw an audit regarding the prescribing of medication for patients with high blood pressure .The GPs realised that when they took over the management of the practice in 2011 that a significant number of patients were on a combination of two specific blood pressure medications

Good

Are services effective?

(for example, treatment is effective)

which was not clinically recommended by NICE. NICE guidelines clearly stated that both medicines could not be used together. After conducting an electronic search between November 2014 and March 2015 the practice found that 28 patients had been previously prescribed both medicines. The practice booked appointments for the identified patients, explained the concerns and they all agreed to stop the medicines. The patients were invited to get their blood pressure checked at two and six weeks. Twenty five of the twenty eight patients had acceptable levels of blood pressure at the start of the process. Once the medication combination was stopped none of the patients showed any increase in blood pressure. The GPs prescribed alternative acceptable medicines for the three patients who had blood pressure that was higher than the acceptable level. The second cycle of the audit was conducted in March 2015. The electronic system and manual searches did not identify any patients on the combination that was not recommended. Following this audit the practice identified learning points that confirmed the combination of the two specific blood pressure medicines did not help reduce high blood pressure but were instead harmful. The practice shared their findings with other practices locally to ensure they also checked their patients' medicines.

Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Another audit conducted by the practice was on cancer diagnosis and two week referral (TWR) referrals in December 2014. The purpose was to review cancer diagnoses and compare referral rates to the clinical commissioning group (CCG) and national averages. The practice found that TWR guidance remained the most appropriate course of action for suspected cancers and the practice found they needed to improve access to secondary care for patients. To support this they contacted the consultants via email or telephone for clinical support for GPs in decision making when diagnosing cancers. The practice conducted a re- audit and found TWR remained the most appropriate referral process.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 76% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease .This practice was not an outlier for any QOF (or other national) clinical targets. The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

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, noting that there was an expectation that all clinical staff should undertake at least one audit a year. We found that all six clinical audits had been completed by different clinicians and they had re-audited to complete the full audit cycle.

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

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register. A sample of patient records viewed showed there was advanced palliative care planning.

The practice also 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

Good

Are services effective?

(for example, treatment is effective)

the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example the practice had a 2% higher number of patients with long term conditions who had received annual care plan reviews in comparison to other practices.

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 some GPs having additional diplomas in sexual and reproductive medicine, diplomas in children's health and obstetrics. 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).

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 training and funding for relevant courses, for example the senior practice nurse had undertaken further training in Infection control in general practice.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, training on administration of vaccines and cervical screening. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had received appropriate training.

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 patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries and information from the 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 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 undertook frequent audit of patients followed-up to ensure any issues were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. We saw examples of minutes of these meetings Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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. Electronic systems were also in place for making referrals.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency (A&E). One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record

Good

Are services effective?

(for example, treatment is effective)

and had this fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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.

Consent to care and treatment

We found that all clinical 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the clinical commissioning group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or practice nurse 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 and nursing staff 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.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 56% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 96 % had received a check up in the last 12 months. The practice had also identified the smoking status of 97% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to appropriate patients. There was evidence these were having some success as the number of patients who had stopped

Good

Are services effective?

(for example, treatment is effective)

smoking in the last 12 months was 65%, which was above average compared to neighbouring practices that were around 50% and national figures. The healthcare assistant responsible for smoking cessation had won a CCG award for their work in smoking cessation and for two years running the practice had the second highest quit rate in the CCG.

Similar mechanisms of identifying 'at risk' groups who needed support were used for patients who were obese and those receiving end of life care. These groups were offered further advice and information in line with their needs such as referrals to a "weight to go "group that was run for patients in the Kingston area to support them with weight loss and nutrition.

The practice's performance for cervical smear uptake was 82% for 2014/2015, which was better than others in the CCG area with an average of 76%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG for the 2014/15 period. A mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, adults and travel, in line with current national guidance. The practice's performance on childhood immunisations during the 2013/2014 period, for children aged three months to 12 months were as follows; Dtap/IPV/Hib (Diphtheria, Tetanus, acellular pertussis (whooping cough), poliomyelitis and Hemophilus influenza type b) 94%, Meningitis C 81%, PCV (Pneumococcal conjugate vaccine) 95% and MMR (measles, mumps, and rubella) 80%. All apart from MMR were above the CCG average.

Flu vaccination rates for the over 65s were 66 %, and at risk groups were 50%. These were similar to CCG averages.

The practice had a clear policy for following up non-attenders by the practice nurse and GP. We saw records that confirmed this was being followed. The practice were also aware that a number of their patients with children were highly mobile as they moved to and from abroad, and as such this impacted on the childhood immunisation data and recall system.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The 2013/14 GP survey results (latest results published in Jan 2015; 359 surveys were sent out, with 123 returned giving a 34% completion rate.) The results were that 70% of patients said they would recommend the practice, compared to a national average of 85%; 80% of patients said they were 'fairly satisfied' or 'satisfied' with the opening hours, compared to the national average of 79%; 69% of patients said that it was 'very easy' or 'easy' to get through on the phone, compared to the national average of 75%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. 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 and 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. The practice switchboard was located away from the reception desk which helped keep patient information private.

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 they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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 GP patient survey 2015 showed 63% of practice respondents said the GP involved them in care decisions, which was lower than the clinical commissioning group (CCG) average which was 81% and 84% felt the GP was good at explaining treatment and results compared to the CCG average of 85%. The results from the practice's own satisfaction survey showed that 81% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice were aware of a higher population of south Asian patients and so knew when to book interpreters. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 65% of respondents to the Patient Participant Group survey carried out in 2014 said they had received help to access support services to help them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we

Good

Are services caring?

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 waiting room, on the television screen and practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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 practice population was comprised mainly of older patients. The practice offered personalised care to meet the needs of this population group. The practice also had a high number of Asian patients and their local needs assessment had identified that diabetes was a common long term condition for that patient group. They offered extensive diabetic care including tier 3 diabetes cares. (Tier three specialist care is a consultant-led care for patients with more complex needs, provided in the community, such as a community-based diabetes clinic, health centre or polyclinic.

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population such as offering a blood tests at the practice and having a dietician on site.

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). Some patients had requested ECG services on site via the PPG surveys. The practice had implemented this and patients were able to have ECG tests (An ECG records the rhythm and electrical activity of your heart) at the practice and this reduced the need for patients visiting secondary care and reduced secondary care referrals. The practice also implemented a monthly audiology clinic for hearing aid users (registered and non-registered patients) to have their hearing aids serviced and repaired

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, there was a higher than expected prevalence of patients with diabetes. Tier 3 services were offered that catered for all diabetes patient care needs and as such patients could be treated in the community rather than in secondary care. (Tier 3 service consists of increased specialist diabetes support at general practices, alongside structured education to GPs and patients, and regular multidisciplinary (MDT) clinics at a range of sites in the area).

The practice had a population of 65% of English speaking patients though it could cater for other different languages through translation services. Staff told us that face to face sessions could be booked if required and access was also available to the translation service via online and telephone services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

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

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Access to the service

The practice was open from 7:30am-18:30pm Monday to Fridays. In addition, the practice offers extended opening hours until 20:00pm on Tuesdays and Thursdays. Consultations run all day from 07:30am. Telephone lines are open until the practice closes in the evenings.These appointments were bookable in advance.

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. These appointments were bookable via the online service, telephone and through walking into the practice. The practice advised that 20- 30% of their appointments were bookable in advance and some appointments were released on the day. The electronic system we looked at confirmed this availability. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

Longer appointments were also available for patients who needed them such as those with a learning disability and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed 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. Comments received from patients 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. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the practice had a designated person who handled all complaints in the practice.

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

We looked at the record of complaints and found that 19 complaints had been received in the last 12 months. All complaints had been dealt with in a timely manner and had been resolved. The practice audited the complaints yearly and noted that a high number of the complaints were to do with the practice administration. The practice sought ways to ensure their services improved and this included arranging staff training and ensuring the reception areas were always fully staffed. The practice offered all patients an opportunity to discuss their complaint face to face if they wished. We also noted that all complaints were discussed and shared with all staff at practice meetings.

The practice reviewed complaints on a regular basis to detect themes or trends. We looked at the report for the last review and found that the common themes were to do with patient waiting times. As a result all staff had been advised to keep patients informed about delays to their appointments. The practice welcomed comments from patients. These were via a suggestion box. Staff told us this was checked monthly and common themes were discussed via feedback in meetings with solutions. Meeting minutes we saw confirmed this.

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. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included to offer a friendly, caring good quality service that was accessible to all patients. The current partners had taken over the practice in 2011 Since then the practice population was steadily increasing and the practice had factored this in their vision and strategy.

We spoke with ten members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

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 10 of these policies and procedures. All 10 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 clinical guidance. The practice also benefited from having a senior partner who was a member of a number of medical boards and another partner who was a clinical commissioning group (CCG) board member. This ensured that the practice was kept in touch with all current issues that were relevant to general practice.

All staff 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 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 had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These audits included the monitoring of prescribed medicines.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as building risks. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We were shown a clear leadership structure which had 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 practice had involved all their staff, clinical and clerical to be part of the presentation to CQC during the inspection regarding what they did well. This demonstrated that all staff was valued and their contributions recognised. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, the induction policy, training, and the management of sickness which were in place to support staff. We were shown the electronic staff

Are services well-led?

Good

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

handbook that was available to all staff, these included sections on equality and harassment and bullying at work. 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 patient surveys, comments cards and complaints. The practice had also introduced a number of services as a result of patient feedback such as the hearing aid service and INR testing.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups; including the elderly, the working age and patients from ethnic minorities. The PPG had carried out quarterly surveys and met every quarter. The practice manager showed us the analysis of the last patient survey of 2014, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had also introduced the Friends and Family Tests (FFT) and results were being analysed and shared with patients. The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

The practice had gathered feedback from staff generally through staff meetings and appraisals. All the staff we spoke with said the practice had an open environment and they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that an "open door" policy was encouraged at the practice. As such they had the opportunity to give their feedback at any time.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at 10 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 to ensure the practice improved outcomes for patients such as complaints and incidents were diagnosed had delayed input in care. The practice had also shared learning from audits with other practices in the CCG to improve patient care.