The Stonebridge Practice

Quality Report

Hillside Primary Care Centre
150 Hilltop Avenue
London
NW10 8RY
Tel: 020 3188 7310
Website: www.thestonebridgepractice.co.uk

Date of inspection visit: 04 November 2014
Date of publication: 05/03/2015

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of The Stonebridge Practice. The practice is registered with the Care Quality Commission to provide primary care services.

We carried out a comprehensive inspection on 4 November 2014. We spoke with patients, members of the patient participation group (PPG), and staff including the management team.

The practice is rated as good for providing a safe, effective, caring, responsive, and well-led service. The quality of care provided for the six population groups is rated as good. We gave the practice an overall rating of good.

Our key findings were as follows:

- Many aspects of the service were safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support development.
- The practice was effective. The practice's focus was on improving patient outcomes, and networked with other local providers to share best practice. They were proactive in health promotion, and raising patients' awareness and understanding in chronic disease management.
- The practice was caring. Feedback from patients about their care and treatment was positive. There was a patient centred culture and strong evidence that staff were motivated to offer kind and compassionate care, working to overcome obstacles to achieve this.
- The practice responded to the needs of its patients, which were central to the planning and delivery of care. They had implemented suggestions for improvements as a result of feedback from patients and the patient participation group. There were many positive examples to demonstrate the changes made. For example, daily walk in clinics in addition to booked appointments had been implemented in response to feedback regarding the availability of appointments.
- The practice understood the needs of the local population and services were planned to ensure these needs were met. They were proactive in understanding the needs of patients with long term conditions,

Summary of findings

particularly diabetes. A weekly diabetic clinic was offered by a GP and nurse with specialist training in diabetic care, and other clinical staff had received training to detect and prevent unwanted outcomes for diabetic patients. The practice also recognised the benefit of supported learning for patients, and made referrals to self-management programmes and signposted patients to educational events in the local area.

- There was an active review of complaints and improvements were made as a result. Learning from complaints was shared with staff and the PPG.
- The practice offered extended opening hours three evenings a week from 18.30 to 19:30 to meet the needs of patients that worked. Text message reminders for appointments and practice updates were heavily utilised.
- The practice was well-led. They had clear vision with clinical excellence and quality of care as priorities. There was a strong focus on learning and training, and staff described a culture of openness and support.

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

The provider should:

- Provide relevant staff with chaperone training.

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 was rated as good for providing safe services. Many aspects of the service were safe. Safety within the practice was monitored and ways to improve were identified. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support improvement, and learning was shared with staff. Risk assessments were comprehensive and areas for improvement were acted upon. The practice recognised that the health care assistants and some staff who acted as chaperones had not received Disclosure and Barring Service checks, and had taken action for these checks to be completed.

Are services effective?

Good

The practice was rated as good for providing effective services. There were systems in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines, and we saw evidence that confirmed these guidelines were influencing and improving practice and outcomes for patients. The practice and its staff were using pro-active methods to improve patient outcomes and networked with other local providers to share best practice. The practice regularly met with other health professionals to coordinate care. Clinical audits were undertaken on a regular basis and results from those audits were used to improve the quality of services provided. The service was provided by staff with the right skills and experience. Staff also received support to develop in their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. Data showed patients rated their interactions with the GPs and nurses higher than average, when compared to other practices in the local area. We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. All patients we spoke to provided positive feedback and said that staff always treated them with respect and compassion. The practice had taken into account feedback for improvement, and we found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

Summary of findings

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. The needs of the practice population were understood and services were planned to ensure these needs were met. There was a proactive approach to understanding the needs of patients with long term conditions, such as diabetes. A weekly diabetic clinic was offered by a GP with specialist training in diabetic care and a diabetic specialist nurse, and other clinical staff had received training to detect and prevent unwanted outcomes for diabetic patients taking insulin. The practice engaged with the Clinical Commissioning Group (CCG) and locality group to secure service improvements where these were identified. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from patients and the patient participation group (PPG). For example, the practice made changes to the appointment system and implemented daily walk-in sessions in addition to booked appointments. There was an active review of complaints and how they were managed and responded to, and improvements were made as a result. Learning from complaints was shared with staff and the PPG.

Are services well-led?

Good

The practice was rated as good for being well-led. The practice had a clear vision which had clinical excellence and quality of care as priorities. There was good leadership and a strong learning culture. The team used clinical audits, performance data, patient feedback, appraisals, and staff meetings, to assess how well they delivered the service and made improvements where possible. There was an open and supportive culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. Staff we spoke with felt valued and were encouraged and trained to improve their skill sets.

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 was rated as good for the care of older people. All patients over the age of 75 had a named GP and were informed of this in writing. The practice's appointment system allowed for walk-in appointments, longer appointment slots and telephone consultations for patients over the age of 70. Scheduled appointments were offered to patients over 75 years, to develop their integrated care plans and identify their specific needs. The practice worked as part of a multi-disciplinary team to take a holistic approach to caring for older patients. The practice recognised isolation as a risk factor for some patients, and supported older patients, patients in nursing homes, patients living in warden-controlled housing, and housebound patients by arranging joint visits with the district nurse. There was a good skill mix amongst the GPs, with some having additional training in geriatric medicine.

People with long term conditions

Good

The practice was rated as good for the care of people with long term conditions. The practice conducted clinical audits which looked at the management of patients with long-term conditions, and changed their practice as a result. Patients with long-term conditions had an annual review which included a review of their condition, medications, and integrated care plans.

When needed, longer appointments and home visits were available for patients with multiple conditions. Scheduled appointments were offered to patients with long term conditions to develop their integrated care plans and identify their specific needs. The practice also worked as part of a multi-disciplinary team to take a holistic approach to caring for patients with long-term conditions.

There was a focus on educating patients and signposting them to disease management classes and support groups to help them self-manage their conditions. The practice also engaged with the Clinical Commissioning Group (CCG) and locality group to secure service improvements where these were identified. For example, a specialist diabetic clinic was run every week by a GP who had additional qualifications in diabetic care, and a diabetic specialist nurse. Other clinical staff had received training to detect and prevent unwanted outcomes for diabetic patients taking insulin.

Summary of findings

Families, children and young people

Good

The practice was rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children who were at risk, and child protection cases were reviewed with the health visitor and midwife during multidisciplinary meetings.

A good skill mix was noted amongst the GPs with most having additional diplomas in areas relevant to the needs of the local population, such as sexual and reproductive health, obstetrics and gynaecology, and family planning. Childhood immunisations were carried out at the practice. The immunisation rate was monitored and take up was good. A baby clinic was run every week, with the opportunity for patients to see the GP and practice nurse on the same day. Appointments were available outside of school hours and the premises were suitable for children and babies.

All new patients registering with the practice were offered a 20 minute health check with the health care assistants, and young people aged 15-24 were routinely offered chlamydia screening during their health check.

Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age people (including those recently retired and students). With the exception of Thursdays, appointments were routinely offered until 6.30pm every weekday. Extended evening hours were available until 19.30 three evenings each week. A walk-in appointment system was also offered daily, with the timetable available to patients on the website and in the practice. Patients could book appointments online, over the phone, or in person. Text message reminders for appointments and practice updates were also utilised.

All new patients registering with the practice were offered a 20 minute health check with the health care assistants. NHS Health Checks were offered to all patients between the ages of 40 and 74. This was an opportunity to discuss any concerns the patients had and identify early signs of medical conditions. Health promotion material was available in all areas of the practice to which patients had access.

The practice's patient participation group (PPG) comprised of representatives from various age groups, with the highest

Summary of findings

proportion aged 45-54. The practice had increased the number of young patients, aged 17-24, attending the meetings. PPG meetings were scheduled in the morning and evenings, taking into account patients' working patterns.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the care of people whose circumstances may make them vulnerable. There was a system to highlight vulnerable patients on the practice's electronic records. The practice held a register of patients with learning disabilities, and longer appointments were offered to these patients. The practice had signed up to enhanced services for patients with learning disabilities, and was carrying out annual health checks for these patients. GPs had undergone further training in the treatment of patients with learning disabilities.

The practice held a register of patients receiving palliative care. There were fortnightly meetings with the district nurse and monthly meetings with the integrated care multidisciplinary group, to discuss the care and support needs of these patients.

There was a system in place for identifying carers, and these patients were offered health checks and immunisations. Referrals were also made to support services so that carers could access further information and support.

Patients were not required to provide proof of address in order to be able to register with the practice, and staff were aware of patients living in vulnerable circumstances such as traveller families. The practice had sign-posted vulnerable patients to various support organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). Longer appointment slots and urgent appointments were available for patients with mental health conditions. Postnatal care was offered to vulnerable patients in a local mental health unit. The practice made referrals to mental health teams and worked closely with

Summary of findings

emotional support organisations. Patients experiencing poor mental health were sign-posted to various support groups including MIND and Certitude. Some clinical staff told us they required updated training in the Deprivation of Liberty Safeguards.	

Summary of findings

What people who use the service say

We spoke with seven patients, and three members of the patient participation group (PPG) during and after our inspection. We reviewed comments from 21 CQC comment cards which had been completed, data from the National GP Patient Survey 2014, and results from 100 patient surveys undertaken by the practice.

Patients we spoke with were happy with the cleanliness of the environment and the facilities available. Patients said staff always treated them with dignity and respect. The GP partners in particular were praised for their compassion and effective treatment. We were told that the GPs and nurses explained procedures in detail and in a way that patients could understand. Many patients commented that access to appointments was previously as issue, but the practice had listened to feedback from patients and the PPG and recently changed their appointment system to include daily walk-in clinics in addition to booked appointments.

The comment cards reviewed were mostly positive and said staff were helpful in addressing patients' needs. Negative comments related to accessing appointments prior to the new appointment system being implemented. An active PPG was in place. This group was a way for patients and staff to listen to each other and work together to improve services, promote health and improve the quality of care. Members of the group told us that the practice listened to their concerns and made changes to the service where possible.

Data from the National GP Patient Survey and the practice survey showed patients were very happy with their interactions with the GPs and nursing staff, with satisfaction levels above the regional averages.

Areas for improvement

- Assess the different responsibilities and activities of staff, and undertake criminal record checks at the appropriate level for staff that require them.

Action the service SHOULD take to improve

- Provide relevant staff with chaperone training.

The Stonebridge Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP Specialist Advisor. The GP Specialist Advisor was granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to The Stonebridge Practice

The Stonebridge Practice provides GP led primary care services to around 4,800 patients living in the surrounding areas of Stonebridge, Harlesden and Wembley, in the London Borough of Brent. The Indices of Multiple Deprivation (2010) shows that Brent is the 24th most deprived local authority (out of 326 local authorities, with the 1st being the most deprived). Stonebridge and Harlesden Wards in this locality have the highest deprivation scores in the borough.

The practice holds a General Medical Services (GMS) contract with NHS England for delivering primary care services to the local community. The practice has a higher proportion of patients between the ages of 0-29 and 40-54, when compared with the England average. The number of patients over the age of 60 is lower than the England average.

The practice has two male GP partners and two female salaried GPs. Other staff include a locum nurse practitioner, two health care assistants one of whom is also a phlebotomist, a practice manager, and eight administrative staff. A diabetic specialist nurse conducts a weekly clinic but is not employed by the practice. Both GP partners work ten sessions per week, and the salaried GPs each cover two sessions per week. The locum nurse practitioner and phlebotomist work ten hours per week, and the health care assistant works 24 hours per week.

The practice is located at Hillside Primary Care Centre, and shares the premises with other health care providers. The practice is open every weekday 09:00 to 18:30 except on Thursday afternoons when it closes at 13:00. Extended hours are offered with the GPs from 18:30 to 19:30 Monday to Wednesday. Walk-in and advanced booking appointments are available daily. The practice opted out of providing out-of-hours services to their patients. On Thursday afternoons and outside of normal opening hours patients are directed to an out-of-hours service or the NHS 111 service. Patients can also be seen at a local hub which provides primary care services to patients within the locality, with additional evening and weekend hours available.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- 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 our inspection we reviewed a range of information we hold about the practice. As part of the inspection process we contacted key stakeholders which included Brent Clinical Commissioning Group (CCG) and Healthwatch Brent, and reviewed the information they shared with us.

We carried out an announced inspection on 4 November 2014. During our inspection we spoke with a range of staff including: two GP partners; practice manager; locum nurse practitioner; phlebotomist; health care assistant; and four administrative staff. We also spoke with the district nurse. We observed how patients were being cared for and sought the views of patients. We spoke with seven patients on the day of our inspection, and three members of the patient participation group during and after our inspection. We reviewed 21 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. Records were kept of significant events that had occurred during the last three years and these were made available to us. A log of national patient safety alerts had been created and stored on the shared drive for clinicians to access. An annual review of complaints was conducted and shared at practice meetings. Lessons learnt were highlighted and actions for administrative and clinical staff were clearly documented.

Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events. We reviewed minutes of the monthly practice meetings which showed reported incidents, national patient safety alerts, and comments and complaints received from patients were shared with staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence that significant events had been monitored since 2008, and we reviewed five significant events that had occurred during the last year. A description of the incident, outcome, analysis and learning achieved were comprehensively documented, and all forms had been reviewed by a GP partner. A recent example was when a computer virus had affected some computer systems in the practice. The incident was escalated to the practice manager, and reported to the relevant IT support teams so that information could be restored from the daily back up. The learning shared with staff at the practice meeting included the importance of backing up the computer systems on a daily basis, and ensuring information was saved on the shared drive rather than individual computers. The practice also shared their experience with the lead for their locality, to prevent such an occurrence at other practices.

National patient safety alerts were received by the GP partners and practice manager, and disseminated by email to all clinicians. Staff we spoke to were able to show us the log of historical safety alerts and told us safety alerts were discussed at clinical meetings to ensure all staff were aware of any relevant changes to practice.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children and adults. There were procedures for escalating concerns to the relevant protection agencies. The practice's policies included contact details for the local safeguarding teams, out of hours access, and named contacts for the designated nurse and doctor for safeguarding children. There was a system to highlight vulnerable patients on the practice's electronic records. Staff were made aware of any relevant issues, such as child protection orders, when accessing patient records.

A GP partner and the practice manager were appointed as the practice leads in child protection and safeguarding vulnerable adults. The GP partner had received Level 3 child protection training and the practice manager Level 2 training, which enabled them to fulfil their lead roles. All other staff were up to date with training in child protection and safeguarding vulnerable adults. Staff knew who the safeguarding leads were, how to recognise signs of abuse, and how to escalate concerns within the practice.

A chaperone policy was in place and visible on noticeboards in the waiting room and outside the consultation rooms. There was no chaperone training for staff, however clinical and administrative staff understood their responsibilities when acting as a chaperone.

Medicines management

The practice manager was the lead for medicines management. Arrangements were in place to ensure medicines kept at the practice were stored securely and only accessible to authorised staff. The 'storage and management of vaccines' policy detailed procedures for ensuring medicines were stored and kept at the required temperatures, and we saw records to confirm fridge temperatures were checked daily. In the event of a potential failure with the fridge or electrical system, medicines which required refrigeration could be stored with another practice in the building, or the pharmacy opposite the practice. The practice manager was responsible for ordering and monitoring medicines to check they were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates, and records confirmed staff checked these daily. Expired and unwanted medicines were disposed of by the pharmacy.

Good

Are services safe?

One GP partner was the lead for prescribing, and we reviewed prescribing audits conducted in conjunction with the local clinical commissioning group. A protocol for repeat prescribing was in place, and designated administrative staff who generated authorised repeat prescriptions were able to describe their duties in line with the legal framework. Staff were aware that patients' medicines may need reviewing following discharge from hospital, and these prescriptions were managed by the GPs.

Repeat prescriptions could be requested online, in person, via e-mail, post, fax or by pharmacist request. It was the practice's policy not to accept orders over the phone for safety reasons. Repeat prescriptions were reviewed every six months by the patient's GP. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin. The practice had direct links with a local hospital laboratory, enabling the GPs to check a patient's blood test results before issuing a prescription for a high-risk medicine.

Vaccines were administered by the nurse using directions that had been produced in line with legal requirements and national guidance. The health care assistant was also able to provide the flu vaccine under instructions authorised by the prescribing GP. The locum nurse was qualified as an independent prescriber, however for safety reasons prescriptions were checked and signed by one of the GPs before being issued to the patient.

Cleanliness and infection control

The practice was visibly clean and tidy. Each room had a cleaning schedule and we saw these records were kept up to date. Signs reminding staff of good hand hygiene techniques were displayed by hand washing sinks, along with soap, hand gel and hand towel dispensers. Patients commented that the practice looked clean, and they had no concerns about cleanliness or infection control.

One GP partner was the lead for infection prevention and control. All staff received annual training, and staff we spoke with were aware of their responsibilities such as using personal protective equipment, and cleaning medical equipment after each use. Annual infection control audits were carried out, with the most recent audit completed in December 2013 by an infection control nurse and the practice manager. Areas for improvement were identified, implemented, and reviewed during a risk assessment audit in August 2014. All actions had been completed including a legionnaires risk assessment.

A specimens handling policy was available, and reception staff were able to describe their actions to implement infection control measures when receiving specimens from patients. We saw specimen bags, disposable gloves, and a box for specimens were stored behind reception.

Equipment

Clinical staff told us they had sufficient equipment to carry out their roles in assessing and treating patients. Equipment was tested and calibrated annually, and we saw maintenance logs to confirm this for items such as blood pressure monitors and the vaccine fridge. Portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

The practice had recruitment policies that set out the standards it followed when recruiting clinical and non-clinical staff. For example, recruitment checks should be carried out for new staff prior to employment, and this included proof of identification, two references, qualifications, registration with the appropriate professional body, and a criminal records check via the Disclosure and Barring Service (DBS) for staff with access to and contact with children or vulnerable adults. There was evidence that the GPs and locum nurse had DBS checks. The practice informed us that the two health care assistants (HCA) and some non-clinical staff who carried out chaperone duties had not undergone a DBS check. We saw evidence that the practice had taken action and contacted their locality group a week prior to our inspection to make arrangements for these staff to undergo a DBS check. The practice should inform the CQC once the DBS certificates have been received.

All new staff underwent a general induction, and the practice had an additional induction checklist for GPs. A hardcopy and electronic copy of the staff handbook was available for staff to access. The most recently employed staff member joined the practice in August 2014, and we saw an induction checklist and a training log had been completed.

The practice planned and monitored the number of staff and mix of staff required to meet patients' needs. A rota

Good

Are services safe?

system was in place to ensure there were enough clinical and non-clinical staff on duty. A capacity audit was conducted in August 2014, to monitor clinical staffing levels and identify risks related to staffing changes such as annual leave. The practice manager informed us that the GP partners did not take annual leave at the same time. When a GP partner was on leave, the other partner carried out extra clinics and extended hours to meet the needs of patients. The practice could also call upon the salaried GPs, other GPs within the practice's locality group, or when necessary a locum GP to cover sessions to ensure there was always a safe number of staff available.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients. A capacity audit to identify risks associated with staffing changes was conducted, and as a result the practice increased the number of health care assistant sessions. Annual risk assessments had been completed in the following areas: health and safety; premises; equipment; infection prevention and control; fire safety; electrical wiring; asbestos; and the storage of medicines, vaccines, specimens and harmful substances. There was a summary of actions taken by the practice as a result of the risk assessments, such as displaying contact details for the occupational health department in the general office for staff to access easily.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records confirmed all staff had received training in basic life support. Emergency equipment was available including oxygen, an automated external defibrillator, and resuscitation equipment, and records confirmed the equipment was checked monthly. Emergency medicines were stored with the emergency equipment, and there were processes in place to check their expiry dates. All the medicines we checked were in date and suitable for use. Staff we spoke with knew where the emergency equipment and medicines were located.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included access to the building, loss of computer and telephone systems, and incapacity of staff. A copy of the document was kept off the premises by the practice manager and the GP partners, where it could be accessible in the event of an emergency. The plan contained relevant contact details for staff to refer to, such as contact details for the electric company in the event of failure to the electrical supply. There was also a communication cascade which highlighted the responsibility of senior staff members to communicate information to other staff within the practice.

A fire risk assessment had been undertaken to maintain safety, and no areas were identified for improvement. The fire alarms were tested weekly, and we saw records that showed staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse were familiar with and followed National Institute for Health and Care Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) guidance around treatment and prescribing. The practice also received regular updates from the Clinical Commissioning Group (CCG). NICE guideline summaries and other clinical information were saved on computer desktops to enable clinical staff to access these with ease.

The GP partners and practice manager attended monthly network meetings with 21 other practices in their locality group. The purpose of these meetings was to discuss current best practice in primary care and updates relevant to the local area. The practice manager also attended monthly meetings specifically for practice managers in Brent. These meetings allowed practice managers to talk about local schemes, and share difficulties they may be facing. Guest speakers also attended to provide information relevant to primary care services and management. The practice kept a record of the minutes and presentations given at both the network and practice manager meetings, and would share relevant information at practice meetings.

The practice showed us previous and current data of their performance for smoking cessation. Last year the practice had achieved a total of 14 'quits'. This year the practice had achieved four 'quits' within the first quarter, out of an annual target of 12. This data was comparable to practices within the locality group, and information was shared with staff and used to support those staff involved in smoking cessation to achieve the annual targets set by the locality group.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical commissioning group (CCG) led clinical audits included the identification and planned management of patients with acute exacerbations of Asthma and COPD, and the identification of un-coded patients with coronary heart disease. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, three patients with asthma exacerbations required onward referrals for further care and the practice had followed British Thoracic Society guidance for Asthma Control to manage these patients.

We reviewed audits relating to medicines management, such as reviewing patients on 12 or more medicines. Following the audit the GPs discussed prescribing at a practice meeting, and altered their prescribing practice.

The practice used the information they collected for the quality and outcomes framework (QOF), a national performance measurement tool, to monitor outcomes for patients. Last year the practice achieved 849/900 clinical points as part of the QOF. The practice achieved 100% in the QIPP programme as well, which was the highest figure in their locality. The Quality, Innovation, Productivity and Prevention (QIPP) programme is a large-scale programme developed to drive forward quality improvements in NHS care, at the same time as making efficiency savings.

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 basic life support, infection control, child protection, safeguarding vulnerable adults, health and safety, and fire safety. A good skill mix was noted amongst the GPs with most having additional diplomas in areas relevant to the needs of the local population, such as sexual and reproductive health, obstetrics and gynaecology, family planning, geriatric medicine, and diabetes.

Three GPs had received their annual appraisal. The fourth GP had returned from maternity leave this year, and was due for appraisal next year. One GP had undergone revalidation in 2013, and the other three GPs were due for revalidation in 2015. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation.

The nurse practitioner was a locum member of staff and had worked at the practice since December 2013. She had extended roles as a diabetes specialist nurse and nurse prescriber. We reviewed training records which demonstrated the nurse practitioner had undergone additional training to fulfil these roles. As the nurse practitioner was a locum member of staff she did not

undergo appraisal with the practice, however she had regular supervision with the GP partners during clinical meetings. The practice was actively seeking to recruit a permanent practice nurse to join the current team.

All staff undertook annual appraisals which identified personal development from which action plans were documented. We reviewed appraisal documentation for the practice manager, a health care assistant, and a member of the administrative team. Staff confirmed that the practice was proactive in providing training relevant to their role. For example, a health care assistant had attended a 'health checks' training course to enable them to carry out this role.

Working with colleagues and other services

The practice worked with other healthcare providers to coordinate patient care. Integrated care multidisciplinary group meetings were held monthly to discuss patients with complex needs, including older patients, patients with long-term conditions such as diabetes and cardiorespiratory disease, and palliative care patients. These meetings were attended by the GPs, hospital consultants, social services and palliative care nurse. If there were child protection cases, the health visitor and midwife were invited to attend.

The practice had a good working relationship with other providers located within the health centre including the district nursing team. The practice engaged in fortnightly meetings with the district nurse and care co-ordinator to discuss patients who were housebound, had complex needs, and had chronic conditions. We reviewed meeting minutes which were well documented. The practice had good communication links with the district nurse, and could make contact over the phone, fax, email, or in person as the district nurse was based within the same premises. During our inspection we spoke to a district nurse, who confirmed the practice worked well with the district nursing team. The district nurse told us the GP partners were accessible over the phone even if they were not working that day. Joint home visits with the district nurse and GP were often arranged to care for the most vulnerable patients and those with complex needs. An example was when a patient who was due for amputation of a toe was managed in the community by the district nurses and the GPs, who liaised with the hospital consultants. The patient completed treatment and no longer needed surgery.

Pathology results were received electronically and managed by the GPs. Administrative staff were given tasks to action, such as booking a patient for a follow-up appointment to discuss test results. Hospital and discharge letters received electronically were placed in a folder on the computer for the GPs to action daily. Paper documents and notifications received were scanned and then placed in the same GP folder.

Information from the out of hours service was received each morning by fax. Staff told us if there were no medication changes or referrals, the information would be scanned and placed in a non-urgent folder of the computer. If medication had been reviewed or a referral sent, these queries were scanned and placed in the GP folder for immediate action.

Information sharing

Clinical staff were responsible for their own referrals and letters, and electronic systems were in place for making these referrals. Most referrals were sent to the Harness Referral Facilitation service, where the referrals were screened to check they were appropriate and then forwarded to the relevant specialist service. The exception to this was urgent two week wait referrals, and antenatal and mental health referrals which were arranged via the Choose and Book system. The health care assistants were also able to send referrals for smoking cessation, weight management, and exercise programmes as part of the health checks.

The practice had signed up to the electronic Summary Care Record, which provides staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information explaining the Summary Care Record was made available to patients on the practice website, including an opt-out form should patients not want their clinical information shared.

The practice had systems in place to provide staff with the information they needed. An electronic patient record, EMIS, was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as hospital discharge letters, to be saved in the system for future reference.

If the practice were full to capacity and unable to see a patient during their opening hours they could send an electronic referral to the Harness Hub who were a primary care provider open until 20.00 on weekdays and selected

Good

Are services effective?

(for example, treatment is effective)

hours on Saturday. After seeing the patient the hub would send an electronic discharge summary to the practice, informing them of the treatment undertaken for the patient.

Consent to care and treatment

Staff we spoke with had knowledge of the Mental Capacity Act 2005 and the Children's and Families Act 2014, however they told us they had not received recent training in the Deprivation of Liberty Safeguards. Staff were aware of when they may need to assess mental capacity. We saw evidence that clinical staff had undergone training in learning disabilities. Patients with learning disabilities were encouraged to attend appointments with a carer, and were supported to make decisions through the use of care plans which they were involved in agreeing. The practice provided an enhanced service for learning disabilities and care plans were reviewed annually, or if there was a change in the patient's health. Practice records showed that so far 21/51 care plans had been reviewed in the current year. Clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Health promotion and prevention

The practice was proactive in health promotion and prevention. Senior staff met with the Public Health team from the Local Authority during the locality network meetings to discuss and share information about the needs of the practice population. This information was used to help focus health promotion activity.

All new patients registering with the practice were offered a 20 minute health check with the health care assistants. If patients had complex health conditions they were followed-up by the GPs at a later date. Young people aged 15-24 were routinely offered chlamydia screening during the health check. The health care assistants told us they discussed lifestyle factors with patients, and provided them with dietary advice and exercise promotion. We were shown the information leaflets and exercise referral forms provided to patients.

The practice also offered NHS Health Checks to all its patients aged 40-74. These were carried out by the health care assistant who was also a phlebotomist. Practice data showed that since April 2014, 151 patients took up the offer of the health check.

The practice could identify patients who needed additional support. The practice kept a register of all patients with learning disabilities and since April 2014, 21 out of 51 patients had received their annual physical health checks. The practice aimed to complete the remaining health checks by April 2015.

Patients with long-term conditions were referred to other services for further care and management. For example, patients with diabetes could access the podiatrists who were based within the same building. The GPs told us that they also made referrals to the 'self-management' team, who ran educational clinics for patients with long-term conditions such as arthritis, heart disease, asthma, and high blood pressure. We saw these information leaflets were available to patients outside the GP consulting rooms.

A weekly smoking cessation clinic was carried out by a health care assistant. The practice data received from the locality network showed that four patients had quit smoking, and seven were near quitting. These rates were similar to neighbouring practices and the practice was on target for reaching their annual quit target of 12.

The practice's performance for cervical smear uptake was 83%, which was above their target of 80%. A member of the administrative team was responsible for following up patients who did not attend for cervical smears. The process involved contacting patients by phone and sending up to three reminder letters. If patients did not want to undergo the screening, they were requested to sign a disclaimer form and were given a leaflet stating they could still attend for screening if they changed their mind at a later date.

A baby clinic was run every week, with the opportunity for patients to see the GP and practice nurse on the same day. The practice offered a range of immunisations for children, travel vaccines and flu vaccines in line with current national guidance. In 2013, practice performance for childhood immunisations for children under the age of two and aged five were both at 90%. This year the practice had provided 430 flu vaccinations for patients of all ages.

The reception area was shared with two other GP providers, and there was a variety of health information available on numerous noticeboards which all patients could access. A health check pod which measured patients' blood pressure, height and weight, was also available for patients to utilise.

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 GP Patient Survey 2014, and a survey of 100 patients undertaken by the practice. These surveys found that patients reported being treated with dignity, compassion and respect by clinical staff. For instance, the National GP Patient Survey showed the practice was above the regional clinical commissioning group (CCG) average for patient satisfaction on consultations with the GPs. Eighty-seven per cent of respondents said the GP was good at listening to them, compared with the lower CCG average of 84%. Eighty-four percent said the GP was good at treating them with care and concern, compared with the lower CCG value of 78%. These results were reflected in the practice survey, with 95% of respondents stating the GP was good at giving them time during the consultation.

The National GP Patient Survey showed that satisfaction scores on consultations with the nurses were also above the CCG average. Eighty per cent of respondents said the nurse was good at listening to them, compared with the lower regional value of 74%. Seventy-seven per cent said the nurse treated them with care and concern, compared with the lower regional average of 72%. There were areas where respondents scored low and that were below the regional average. Forty percent of respondents said it was easy getting through to the surgery by phone, which was lower than the CCG average of 67%. Fifty-three per cent of respondents described their experience of making an appointment as good, which was below the CCG average of 69%. These areas for improvements were also reflected in the practice survey results. The practice had analysed the data from both surveys, and we saw minutes to confirm the issues were discussed during Patient Participation Group (PPG) meetings. As a result, the practice had recently changed their appointment system.

We received 21 CQC comments cards where patients shared their views and experiences of the service. The majority of comments were positive. Patients said staff were polite, helpful and took the time to understand their needs. Patients said the GPs were knowledgeable, treated them with dignity and respect, and were kind and caring in their approach. Four comments were less positive and the common themes mentioned were the difficulties in booking an appointment. We also spoke with ten patients, three of whom were members of the PPG. They all spoke positively about the care they had received at the practice, and said their dignity was always respected. The GP partners in particular were praised for their compassion and effective treatment.

There was a confidentiality policy in place, and reception staff told us that if a patient requested to speak with them in confidence they could access a private room behind reception. However, patients we spoke with were not aware of this and we did not see any notices informing patients about it. The National GP Patient Survey showed 44% of respondents were satisfied with the level of privacy when speaking to receptionists, and this was below the regional average. Members of the PPG told us this issue had been raised with the practice at previous meetings. The practice had taken action in response to patient feedback. Markings on the reception floor indicated that patients should stand behind a line when waiting to speak with reception staff, allowing the patient at the reception desk a degree of privacy when talking with staff. We observed patients adhering to the queuing system.

There was a clear screen between patients and reception staff, and patients were required to speak through an open section in the screen. We observed that some patients found it difficult to position themselves so that the receptionist could hear them, and needed to move to a lower screen to improve communication. Staff told us the screen had been installed in response to an incident where a staff member's safety was threatened. We also saw a notice in reception stating the practice's zero tolerance policy for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Information from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Data revealed 78% of respondents found their GP was good at involving them in decisions about their care, which was above the CCG average of 72%. Eighty-six per cent felt the GP was good at explaining tests and treatments, which was higher than the CCG average of 80%. Results for the same interactions with nursing staff showed 73% of respondents stated the nurse was good at

Good

Are services caring?

involving them in decisions about their care, above the regional value of 65%. Eighty per cent said the nurse was good at explaining tests and treatments, which was higher than the CCG average of 73%.

Patients we spoke to told us they felt listened to and involved during consultations. They also stated that clinical staff took the time to explain their treatment options, and some patients said they were given information leaflets to help them make informed decisions about their care.

Scheduled appointments were offered to patients over 75 years, and for patients with long term conditions to develop their integrated care plans and identify their specific needs. Annual health check reviews were offered throughout the year to patients with learning disabilities, and we saw evidence that these were being done.

An interpreting service was available for patients who did not have English as a first language, and we saw notices in the reception area informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The practice made referrals to emotional support services such as Improving Access to Psychological Therapies (IAPT), Brent bereavement service, Junction drug and alcohol services, EACH, MIND, and Brent Mental Health teams. The practice also worked closely with Certitude, who provide support for people with learning disabilities, autism and mental health needs, and worked within the same building. We saw evidence that staff attended meetings where these support organisations were invited to give presentations on their services.

There was a system in place for identifying carers and the practice currently had 54 patients registered as carers. Staff were aware of patients' needs and told us that carers were offered health checks and immunisations. Referrals were also made to Brent Carers Centre so patients could access further support and information. There were notices in reception informing patients that a carer's pack could be requested, and reception staff were able to provide us with the information given to carers.

The practice recognised isolation as a risk factor for some patients, and supported older patients, patients in nursing homes, and patients living in warden-controlled housing, by arranging joint visits with the district nurse. We spoke to a manager at a local nursing home, where two residents were patients of the practice. The GPs visited the home weekly or more frequently when there was a change in the patient's needs. The manager told us that the GPs were caring and supportive to both patients and staff. They told us that patients were involved in their care as much as possible, and that the GPs were very easy to contact in emergencies.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The areas of Stonebridge and Harlesden wards have the highest deprivation scores in the borough of Brent. The practice understood the needs and challenges facing the practice population, and services were planned to ensure these needs were met. There was a proactive approach to understanding the needs of patients with long term conditions. For example, the practice identified there was a need for improved diabetic care and management as a result of their previous quality and outcomes framework (QOF) results. The practice carried out further analysis on the potential barriers in achieving improved diabetic care, such as poor compliance with treatment, reluctance for patients to commence new medicines, and a high percentage of patients not attending review clinics. As the reported prevalence of diabetes was higher for the practice's locality area when compared to the clinical commissioning group (CCG) value, the CCG commissioned for a diabetic specialist nurse to attend the clinic once a week. As a result the practice offered a weekly diabetic clinic which was managed by a GP with specialist training in diabetic care, and the diabetic specialist nurse. All clinical staff attended insulin management training, which helped staff detect and prevent unwanted outcomes for patients. We also saw that patients were signposted to self-management classes, and were made aware of relevant clinical commissioning group (CCG) educational events for patients.

Senior practice staff attended local networking meetings with practices in their region, and we saw minutes of these meetings. The GP partners told us they were able to contribute their ideas about improving clinical services that would benefit the local population, such as the creation of the Harness Hub which provided extended hours for patients to access primary care services in Brent. The practice also shared its clinical mixed skills with the CCG and offered minor surgery services to practices within the locality network. Monthly minor surgery audits were conducted and looked at the activity of surgery and procedures undertaken.

The practice had five patients on their palliative care register. There were fortnightly meetings with the district nurse and monthly meetings with the integrated care multidisciplinary group, to discuss the care and support needs of these patients.

One of the GP partners led on antenatal and postnatal care. Mother and baby checks were also offered to vulnerable patients in a local mental health unit, and a nurse from the unit attended the practice with the baby if the mother could not be present.

Patients could access a male or female GP. All patients had a named GP upon registering, and patients over 75 years old were sent a letter notifying them of their named GP. Routine appointments with the GPs were 10 minutes, and the practice offered double appointments for patients who might require them, including patients with learning disabilities, mental health conditions, multiple long-term conditions, and those over the age of 70. Patients with mental health conditions were also offered urgent appointments. Reminders on how to prioritise these patients were discussed with staff during practice meetings and we saw minutes to confirm this had occurred at the last two meetings. Home visits and telephone consultations were also available to patients who required them, including housebound patients and older patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG) and patient surveys. For example, patients commented negatively about the length of time it took to receive a routine appointment. The practice conducted audits and identified there was a high rate of non-attendance at booked appointments, which was a contributing factor to the waiting time. This data was presented to the PPG, and an action plan for changing the appointment system was developed whereby daily walk-in clinics would be introduced. Most patients we spoke to on the day had attended the walk-in clinic rather than a pre-booked appointment.

Tackling inequity and promoting equality

The practice understood the needs of different groups of people to deliver care in a way that met these needs and promoted equality. This included patients who were in vulnerable circumstances or who had complex needs. The GPs informed us that there were three 'traveller' families registered with the practice, and patients were not required

Good

Are services responsive to people's needs?

(for example, to feedback?)

to provide proof of address in order to be able to register with the practice. These patients were registered as permanent patients rather than temporary patients. The practice manager informed us this was because temporary records were deleted after a period of time and if the patient attended at a later date, their records would not be available.

The practice had access to an interpreting service, and some members of staff spoke other languages. The practice had a higher proportion of Somali patients, and one of the health care assistants was available to translate during consultations.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was based on the first floor and lift access was provided to assist people with mobility difficulties. A hearing loop was available at reception to assist patients who had a hearing impairment. Disabled toilets and baby changing facilities were also available. All staff had completed equality and diversity training, which was included in the practice's mandatory customer service training. Patients commented that staff were receptive and attended to their needs.

The reception waiting area was shared with two other GP providers. There were automated check-in screens to allow patients to check themselves in for an appointment, or patients could also approach the reception desk. The practice previously identified that improvements needed to be made to the reception area, and as a result the building's management renovated the waiting area to improve safety and increase capacity.

Access to the service

Services were delivered in a way to ensure flexibility, choice and continuity of care. The practiced was open 09.00 – 18.30 every weekday with the exception of Thursdays, when it was open from 09.00 – 13.00. On Thursday afternoons and outside of normal practice hours patients were directed to an out-of-hours service.

The practice had implemented a new appointment system two weeks prior to our inspection, in response to patient feedback on the availability of appointments. Walk-in clinics were now offered twice a day in addition to pre-booked appointments. Walk-in sessions were available for two hours each morning, and one to two hours each afternoon with the exception of Thursday. Patients were made aware of the changes by text message, leaflets, and on the practice website. We saw leaflets available in reception which detailed the change of appointment system and specific times for the walk-in clinics. Patients we spoke to were aware of the new walk-in clinics and welcomed the change to the way appointments were now managed.

Extended opening hours were available Monday to Wednesday from 18.30 – 19.30. This was useful for patients who could not access the practice during working hours. Patients could book appointments online, over the phone, or in person. Text message reminders for appointments and practice updates were also utilised.

If the practice was full to capacity and unable to see a patient during the day, they were able to refer patients to the Harness Hub which saw patients until 20.00 every evening, and selected hours on Saturday. This information was advertised to patients in the waiting room. Patients we spoke with had not needed to use the hub service as the practice had always managed to see them for urgent appointments.

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 manager was the designated responsible person who handled all complaints in the practice.

There was an active review of complaints and how they were managed and responded to, and improvements were made as a result. The practice conducted an annual complaints review to identify any themes and areas for improvement. We looked at the report for the last review and noted that lessons learnt and areas for improvements had been documented for both clinical and non-clinical staff. For example, administrative staff had been reminded to check patients' mobile telephone numbers so that text message reminders could be sent to the most up to date number. During our inspection we observed reception staff following these procedures when talking with patients over the phone and in person.

There was a notice in the reception area informing patients how to make a complaint. A complaints log was kept and we reviewed the six complaints received in the last six months. These had been investigated and responded to in

Good

Are services responsive to people's needs?

(for example, to feedback?)

a timely manner. Staff told us that complaints received were discussed during practice meetings to ensure all staff were able to learn and contribute to determining any improvements that may be required. We reviewed the minutes from practice meetings which showed evidence of shared learning from complaints with clinical and non-clinical staff. All the staff we spoke with were aware of the system in place to deal with complaints, and that feedback was welcomed by the practice and seen as a way to improve the service. Staff told us they would try to diffuse any complaints, and then direct patients to the practice's complaints policy or practice manager. Members of the patient participation group told us that they were involved in reviewing some complaints and were able to feedback suggestions for improvement.

The patients we spoke with told us they would be comfortable making a complaint if required. Most patients told us they would approach the GP partners in the first instance, and said they were confident their complaint would be investigated fairly.

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 maintain clinical excellence and provide a high level of care to improve the health of the local population. Strategies included expanding the range of services available to patients, and forming partnerships with patients based on mutual respect, holistic care, and continuity of care. We saw a five-year business plan in place, and this highlighted the practice's aspirations. We spoke with ten members of staff. They were all aware of the vision and values of the practice and knew what their responsibilities were in relation to these. We saw that the regular staff meetings helped to ensure that the vision and values were being upheld within the practice, however they had yet to display their aspirations for patients to view.

There was also a strong focus on learning and training for all staff. Two GPs were involved in mentoring medical students and were to become GP appraisers, there was close supervision of clinical staff, and internal annual appraisals were in place for all staff with the exception of the GPs and locum staff. The practice provided minor surgery services, and we saw the GP partner responsible for these services had received training and kept up to date with continuing professional development in this area. The practice also recognised the benefit of supported learning for patients, and an example was referring patients to self-management programmes to enhance their ability to self-manage their long-term conditions.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice intranet. All the policies we looked at had been reviewed and were up to date.

There was a clear governance structure in place. The management team consisted of the two GP partners and the practice manager, and they met on a regular basis to discuss how the practice was run. They also attended meetings with the Clinical Commissioning Group (CCG), local networking group, and local practice managers. The practice regularly submitted governance and performance data to the local networking group so that performance in areas such as smoking cessation could be benchmarked against other practices in the locality.

The practice had arrangements for identifying, recording and managing risks. We saw a risk log which addressed a range of potential issues including health and safety, infection prevention and control, and fire safety. Risk assessments were conducted annually, or following an incident. Action plans had been produced and implemented.

Leadership, openness and transparency

We were shown a leadership structure which had named members of staff and their job title. The practice had documented lead roles in the various policies and procedures. For example, a GP partner was the lead for safeguarding and this was recorded in the Child Protection Policy, and Safeguarding Vulnerable Adults Policy. The ten members of staff we spoke with were clear about their own roles and responsibilities, and also those of their colleagues. They told us they felt valued, well supported, and knew who to approach in the practice if they had concerns.

A hard copy and electronic version of the staff handbook was available to all staff, and included sections such as the annual appraisal process. A whistleblowing policy was in place, and staff we spoke with knew how to access this if required.

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

The practice had gathered feedback from patients through the patient participation group (PPG), National GP Patient survey, in-house practice surveys, and complaints received. As a result of the last surveys, which showed patients were dissatisfied with the length of time it took to receive an appointment, the practice had changed their appointment system to include daily walk-in and advance booked appointments. Patients also commented on the length of time it took to access the practice over the phone. The practice arranged for an external company to conduct an audit of the telephone system, to assess the volume of calls and length of time patients were waiting. As a result of the audit, parts of the telephone system were reconfigured, an extra member of staff was allocated to work at reception to help answer calls, and staff were reminded to answer phone calls within a period of time.

The practice had an active PPG. The PPG contained representatives from various age groups, with the highest proportion (35%) aged 45-54. The practice's action plan for

Are services well-led?

Good

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

the year before included increasing the number of young patients aged 17-24. Since then, the practice had managed to recruit an additional young person aged 17-24 to join the PPG.

The PPG was open to all patients and meetings times alternated between the morning and evening, taking into account patients' working patterns. At times up to 30 patients had attended for meetings. Information about the PPG was available on the practice's website and notices were displayed in the reception area. Staff also actively encouraged patients to join the group. Meetings were held at least once a quarter and patients were notified in advance by text message, email, telephone or face-to-face of any meetings.

Members of the PPG told us they felt valued and thought their views were listened to. We were given examples of where the PPG had highlighted areas where improvements could be made, for example privacy at the reception desks. They told us the management team listened to their concerns, and had made improvements.

We saw minutes from practice meetings which were held monthly. Staff told us that there was an open culture within the practice and the practice meetings provided an opportunity to provide feedback. Staff also commented that the management team were approachable, and they could speak with them in private if they could not raise their concerns during practice meetings.

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 staff files and saw regular appraisals, which included a personal development plan, took place annually. GPs also received appraisal through the revalidation process, and the practice kept records of the GPs' last appraisals. The nurse practitioner was a locum member of staff and did not undergo appraisals with the practice, however she attended clinical meetings where clinical support and supervision were provided.

The practice had plans to become a GP training practice. Two GPs lectured and mentored medical students and had been offered posts to become NHS GP appraisers. There was also a strong focus on learning and training and staff told us they could request training in areas they felt needed developing, such as IT support. A health care assistant told us the practice arranged for them to attend training and educational seminars relevant to their clinical role. We also saw evidence that the practice had organised for staff members to complete a national vocational qualification relevant to their job description.

The practice had completed reviews of significant events and other incidents, and these had been shared with staff during practice meetings to ensure the practice improved outcomes for patients. Part-time staff told us if they were unable to attend a meeting, they would access the minutes at a later date so that they were kept up to date with any changes that may have been implemented.