Ellis Practice

Quality Report

Chalkhill Primary Care Centre
Welford Centre
113 Chalkhill Road,
Wembley,
London HA9 9FX
Tel: 020 8736 7198
Website: www. theellispractice.nhs.uk

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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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Ellis Practice on 28 October 2014. Overall the practice is rated as good.

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

Our key findings were as follows:

- Some arrangements were in place to ensure patients were kept safe. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice.
- We saw from our observations and heard from patients that they were treated with dignity and respect.
- The practice understood the needs of their patients and was responsive to them. The practice had access to Kingsbury Hub, which was a backup service staffed by a nurse practitioner and locum GP's and contracted by the CCG. The Hub provided an emergency GP service six days a week to patients from a number of practices in the London Borough of Brent
- The practice was well-led, had a defined leadership structure and staff felt supported in their roles.

However, there were also areas of practice where the provider should make improvements:

- The practice should ensure that all staff who are required to chaperone patients receive the appropriate training.

Summary of findings

- The practice should ensure that all non-clinical staff receive training in safeguarding vulnerable adults.
- The practice should ensure the oxygen cylinder kept on site is regularly checked to ensure it contains oxygen and can therefore be used in a medical emergency.
- The practice should ensure learning from significant events is disseminated to non-clinical staff.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated 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 people safe. However, non-clinical staff had not received training in adult protection and administration staff who were required to act as chaperones on occasions had not received chaperone training. An oxygen cylinder was available on site, although on the day of our visit we found it was empty

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's capacity to make decisions and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out staff appraisals and had established personal development plans for all staff. There was evidence of multidisciplinary working to discuss the needs of complex patients especially those on care plans. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. They also had access to counselling resources located in the same building for those people with substance misuse concerns.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others in the borough for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. Patients who had care plans had annual reviews or more frequently where needed.

Summary of findings

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients 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 CQC patient comment cards we received was also positive and aligned with these views. GP's told us they would make phone calls to families who had suffered bereavement and offer to refer them to appropriate services for support.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and all vulnerable patients had a named GP. There was evidence of continuity of care and people were able to get urgent appointments on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice reviewed complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon in a timely manner. The practice used a telephone translation service and had access to an interpreter who was based in the building. The premises were accessible to patients with disabilities, for example there was lift access to the first floor where the surgery was based and the toilets were accessible to wheelchair users.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its key priority. The strategy to deliver this vision had been produced in consultation with staff, other professionals and the CCG and was regularly reviewed and discussed at team meetings and away days. High standards were promoted and owned by all practice staff and teams worked together across all roles. The practice carried out proactive succession planning and had started to plan for the retirement of a senior partner. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients through an internal patient survey organised

Summary of findings

by their patient participation group (PPG), who met quarterly. Two members of the practice PPG also attended the locality PPG consisting of 10 other practices and contributed to developing locality wide pathways for patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of specialist services, for example dementia and end of life care. The practice was responsive to the needs of older people and used the BIRT2 tool to identify risk and plan care including offering home visits and making regular contact with patients they knew lived on their own or were vulnerable to prevent unnecessary hospital admissions. All patients over 75 years of age had a named GP who looked after their care and treatment. The named GP held regular meetings with other health care professionals to provide multidisciplinary care for older patients and liaised with appropriate health care professionals when required to ensure older patients received effective care.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this population group that had a sudden deterioration in health. When needed longer appointments and home visits were available. Patients with a long term condition had a named GP and a care plan and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nursing staff had received appropriate training to manage and support patients with long term conditions such as spirometry. The practice had GP leads for a variety of chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD) and asthma.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, they had links with the local children's centre where they would refer families for additional support and had multidisciplinary meetings with health visitors where any safeguarding concerns would be discussed. There were weekly immunisation baby clinics and immunisation rates were relatively high in comparison to other practices in the CCG, for all

standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The GPs offered family planning advice, fitted IUDs and prescribed the contraceptive pill.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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. They had extended opening for one hour one day a week and online services for ordering repeat prescriptions, booking appointments and getting test results were available. The practice offered a full range of health promotion and invited patients over 40 years of age to have an NHS health check.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. All vulnerable patients had a care plan that was reviewed annually. The practice had carried out annual health checks for people with learning disabilities and 90% of these patients had received a follow-up review within a year. The practice offered longer appointments for people with learning disabilities and visited some patients who lived in local residential homes.

There were GPs within the practice who specialised in drug and alcohol misuse. These GPs had completed parts one and two of the Royal College for General Practitioners (RCGP) Alcohol Misuse certificate.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Summary of findings

Practice staff had access to an interpreter and translation service via language line to ensure that those patients whose first language was not English could access the service. The practice was accessible to disabled patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). All these patients had a care plan that had been reviewed annually and 70% of people experiencing poor mental health had received an annual physical health check in the previous 12 months. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. The practice offered longer appointments for people experiencing poor mental health and visited some patients who lived in local residential homes.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector local organisations including the community centre located in the same building. The GPs liaised with the local community mental health team when required and had an understanding of the Mental Capacity Act 2005

The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. 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 11 patients during our inspection and received 34 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were very positive about the practice

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care. This was similar to the findings of the latest national GP patient survey which found that 91% of respondents described their overall experience of the practice was good and 85% said that they would recommend the practice to someone new.

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure that all staff who are required to chaperone patients receive the appropriate training.
- The practice should ensure that all non-clinical staff receive training in safeguarding vulnerable adults.
- The practice should ensure the oxygen cylinder kept on site is regularly checked to ensure it contains oxygen and can therefore be used in a medical emergency.
- The practice should ensure learning from significant events is dissemination to non-clinical staff.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second inspector, GP and an expert by experience who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to Ellis Practice

Ellis Practice provides GP primary care services to approximately 8,000 people living in the London Borough of Brent. The practice is staffed by seven GPs, two male and five female who work a combination of full and part time hours. The practice employed one nurse practitioner, a nurse, a healthcare assistant, a phlebotomist, a practice manager and twelve administrative staff. The practice held a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice was registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours were 8.00am to 6.30pm Mondays, Wednesday, Thursday and Fridays and 7.00am to 7.30pm on Tuesdays. The out of hours services were provided by an alternative provider. The details of the 'out of hours' service were communicated in a recorded message accessed by calling the practice when it was closed and details could also be found on the practice website. The practice provided a wide range of services including clinics for asthma, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provided health promotion services including a flu vaccination programme, weekly smoking cessation clinics and cervical screening.

The national census data stated 18% of the borough's population was white British, 18% white non-British (among which are large, Polish and Irish communities), 8% black Caribbean, 8% black African (amongst which are a large Somalian community) with various other ethnicities (including Indian, Pakistani, Chinese and Sri Lankan) making up the remaining 48 percent. Around 62% of children under 16 in Brent were classified as living in poverty in 2011, higher than the overall percentage for London (27%) and England (21%). The practice's catchment area has a high deprivation score and young mobile population.

The CQC intelligent monitoring placed the practice in band three. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

Detailed findings

How we carried out this inspection

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

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit 28 October 2014. During our visit we spoke with a range of staff (doctors, nurse, senior administrator and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

The practice used a range of information to identify risks and improve patient safety. They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. Administrative staff and receptionists were encouraged to log any significant event or incident and bring them to the attention of the practice manager. We saw there was a template for recording significant events and incidents and the staff we spoke with were aware of their responsibilities to raise concerns. Staff knew how to report incidents and near misses which were discussed at the GPs weekly meeting. Meeting minutes evidenced that GPs had discussed a case where a vulnerable older person with a serious long-term health condition had been discharged by the hospital. Despite the person being vulnerable the hospital had not contacted the GP or social services before they were discharged which led to them being returned to an unstable home situation without appropriate support arrangements being put in place to address their social and care needs. As a result the GP practice had implemented a process for staff to contact hospitals regularly when they were aware that vulnerable patients had been admitted.

GPs told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at the significant events from April 2014. Records showed staff were appropriately reporting incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw evidence to confirm that the practice had completed a significant event analysis (SEA) annually which included identifying any learning from the incident. For example we saw a learning point from the above incident was to watch out for communication breakdown between primary, secondary and tertiary care. However, we found there was no formal process for discussing SEA's with staff, other than the GP's. There was no evidence of learning and dissemination to non-clinical staff, who told us they sometimes hear about incidents by 'word of mouth' from colleagues.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with told us of recent alerts they had discussed regarding preventing healthcare associated infections. They also told us that alerts were discussed at six weekly practice 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 up to date child protection and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers.

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding children. Clinicians were trained to level three and non-clinical staff were trained to level one. We asked members of medical, nursing and administrative staff about their safeguarding training and were told that only clinical staff had received training in adult protection.

However most non clinical staff we spoke with 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, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were displayed on the walls in the general office and the GP surgeries and were easily accessible on the intranet.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic patient records. This included information so that staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw where there had been recent concerns about a child an alert was

put in the records so that staff would observe interaction between the family when they attended the surgery. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services. Further, as health visitors' were located in the same building, face to face meetings occurred for individual patients when there were concerns.

A chaperone policy was in place copies of which were visible on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone administration staff had been asked to carry out this role. However, we were told that chaperone training had not been undertaken by these staff members although staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff with chaperone duties had been DBS checked.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals. 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. For example, one audit had identified that some vulnerable patients care plans had not been updated following annual reviews.

Medicines management

Medicines were stored in medicine refrigerators in one of the treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge.

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.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The practice manager was responsible for generating repeat prescriptions. 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 in locked drawers in the nurses office. The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

GPs reviewed their prescribing practices as and when medication alerts were received. We saw that GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to keep abreast of updated medication information.

Cleanliness and infection control

We observed the premises was clean and tidy. We saw cleaning of the premises was the responsibility of the CCG who also carried out infection control audits. Cleaning records were kept which showed that most areas in the practice was cleaned daily, and the toilets were checked regularly throughout the day and cleaned when needed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

One GP was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training on infection control specific to their role and received annual updates. We saw evidence that an infection control audit had been carried out in October 2014 and that any concerns identified for action were completed on time. For example, we saw that a sharps bin in one surgery was found to be full and had not been labelled, however on the day of our visit all bins were labelled and none were overflowing. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. Personal

protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they would always wear gloves to accept specimens from patients as stated in the infection control policy.

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 that the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient 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 which showed tests had been carried out in March 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors nebulisers and weighing scales.

Staffing and recruitment

The practice had a recruitment policy in place which was up-to-date. Appropriate pre-employment checks were completed for staff before they started work at the practice. We looked at a sample of recruitment files for GPs, administrative staff and nurses and found they contained proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

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 ensure patients were kept safe. There were procedures to follow in the event of staff absence to ensure smooth running of the service. The senior administrator occasionally provided cover in reception during busy periods.

The GP partners and practice manager told us about the arrangements for planning and monitoring the number 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. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

The lead GP told us they had recently reviewed the staffing levels and skill mix and had identified a need to increase their GP staff cover by two sessions per week and were in the process of recruiting a part-time salaried GP.

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 which staff were required to read as part of their induction which was accessible on the intranet for all staff. One GP at the practice was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk matrix maintained by the practice manager and graded risks as low, moderate, high and extreme. Each risk was assessed, graded 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 a recent risk assessment had identified that people were wedging fire doors open and therefore people were at risk of inhaling smoke if a fire broke out, increasing the speed of the fire spreading and death. They had therefore agreed that staff needed to be reminded not to wedge the door open and that the last person to leave the building was to ensure all fire doors had been closed.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health. For example the practice kept a register of vulnerable patients which provided alerts to staff to follow up on attendance and results when patients in this group where referred for tests and medical procedures. This ensured they were able to inform GP's when patients had not attended for tests.

Requires improvement

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. An oxygen cylinder was provided by the landlords of the building, for use by the practice, however on the day of our visit we found it was empty. We were told it was the responsibility of the facilities to manager. The practice manager told us they would inform them of this after our visit. There was also an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed this was checked regularly.

Staff told us they had training in basic life support including cardiopulmonary resuscitation (CPR) and other emergencies such as fire and floods. Staff records showed all staff had received training which was updated every two years.

Emergency medicines were available and were kept secure on a trolley in one of the administration offices 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 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 covered areas such as long or short term loss of the main premises, loss of the computer system/ essential data, loss of access to paper medical records, loss of the telephone system, incapacity of GPs and loss of supplies. The document also contained relevant contact details for staff to refer to. For example, contact details of the site manager for the owners of the building, all staff contact numbers and email addresses and contact details for locum doctors. The plan was reviewed every year at the practice away day.

A fire risk assessment had been undertaken that included actions required to maintain fire safety.

For example we saw it had identified fire alarm tests should be carried out every week and that fire drills should occur at least every year. We saw records to confirm the alarm had been tested weekly and a fire drill was due as the last one had occurred October 2013. We saw records that staff were up to date with fire training.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this as the practice had prepared a plan to address the future retirement of one of the senior partners.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw the practice had weekly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The GPs and nurses told us staff completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

The GPs told us there was a lead for all specialist clinical areas such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease (COPD. The practice nurses supported this work, for example due to high practice awareness of diabetes in ethnic minority population. The practice had a GP lead and a nurse practitioner lead. The nurse practitioner had a diploma in diabetic management. Weekly clinics were supported by the diabetes liaison nurse and the diabetologist from secondary care. We saw quality and outcomes framework (QOF) scores for diabetes management was 96%. Health care assistants were qualified to monitor physical health such as blood pressure and to take blood samples.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. Review of the clinical meeting minutes confirmed that this occurred at least once a month. For example the practice had recently received guideline on management of people with COPD and the practice had identified where improvement can be made. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes, which was approximately two percent of the practice patients. 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. Discharge summaries were sent to the practice manager who would liaise with the relevant GP to book an appointment, either at the surgery or the patients' home.

We saw they had carried out a review of their referrals to secondary care in April 2014, where they looked at sources of secondary care referrals in a three month period and compared their own performance with local guidelines. They found they had referred in line with local guidance and were performing better than other local practices. As a result of discussions with local practices new local pathways in Paediatrics, Trauma & Orthopaedics and ENT were developed for the area.

We saw no evidence of discrimination 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. Patients told us they had never experienced any discrimination at the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us nine clinical audits that had been undertaken in the last year. Four of these were completed audits i.e. the practice had re-audited. The practice was able to demonstrate the changes resulting since the initial audit. For example an audit of asthma/ COPD exacerbations had been carried out and on first audit the percent who had a medication review and annual review ranged from 57% and 59%. After intervention, on re-audit the percent had increased to 89% and 100%. This was a full cycle audit which showed positive outcomes for patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. QOF is a national performance measurement tool. For example we saw an audit regarding patients taking 12 or more medications following a medicines management alert the practice carried out face-to-face medication reviews on all these patients and showed us data showing decreases in the numbers of prescriptions for most patients which lowered the risk of interactions.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 80% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in asthma. This practice was not an outlier for any QOF (or other national) clinical targets.

GPs told us they were committed to maintaining and improving outcomes for patients.

The QOF report from 2012-2013 showed the practice was supporting patients well scoring 999 out of 1000. QOF information for 2013-2014 indicated the practice had maintained this level of achievement scoring 888 out of 900.

Clinical 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.

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 asthma and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had a good understanding of best treatment for each patient's needs. The practice 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.

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 the area. This benchmarking data showed the practice had outcomes that was doing better than other services in the area. For example, the practice was amongst four out of 20 practices that were achieving the CCG target budget for prescribing medication.

Effective staffing

The practice staff team 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. A good skill mix was noted amongst the doctors with four GPs trained to administer methadone medication. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The staff induction programme covered a wide range of topics such as health and safety, basic lifesaving, child protection and fire safety. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example reception staff told us they had received information technology training, in relation to the patient's database and customer care training.

Non–clinical staff told us they had regular opportunities to hold discussions about their work during the week, as the practice manager operated an 'open door' policy. Clinical staff received monthly clinical supervision. All staff received annual appraisals which identified learning needs. Non-clinical staff were appraised by the practice manager and clinical staff were appraised by one of the partners. Staff records demonstrated that most appraisals were up to date, however some reception staff had not been appraised in the last 12 months. We saw performance and personal development were discussed at these meetings. There were arrangements in place to support clinical staff through the revalidation process. For example the salaried GPs were supported to attend study days in regards to any updates in key aspects of their role such as prescribing mental health medication.

Administrative staff we spoke with confirmed that the practice was proactive in providing training and funding for development courses. For example, a receptionist had been supported to attend a health care assistant course and the assistant practice manager had completed a course to offer breast feeding advice to new mothers.

Good

Are services effective?

(for example, treatment is effective)

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 people's needs and manage complex cases. Blood results, X-ray results, letters from out of hour's providers the NHS111service and local hospital including discharge summaries were received electronically. All relevant staff were aware of their responsibility for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP reviewing 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 within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients e.g. those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. The district nursing team who was based in the same building as the practice confirmed they met regularly with the GPs to discuss care planning concerns and often had ad hoc discussions when they had serious concerns about patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. An electronic system was also in place for making referrals for tests or to see specialists. The practice did not regularly use the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) as staff told us they encountered a number of difficulties with this system and found it easier to arranged hospital appointments manually via the phone, fax or emails. A record of each referral including the sent date was maintained on a spreadsheet by the administration staff to monitor for any delays. Urgent two week referrals for suspected cancer symptoms were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw the practice manager carried out ad hoc audits to assess the completeness of these records and that action had been taken to address any shortcomings identified, for example where care plans had not been updated following reviews.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in relation to assessing a person's capacity to give consent. Clinical staff had received training on the Mental Capacity Act 2005. 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 example one GP told us about an older person with Dementia. A capacity assessment had been carried out and a best interest meeting had been held with the relative and as a result 'end of life' care arrangements had been made.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of these patients to help ensure they received the required health checks. These patients were offered annual review appointments with their carers during which they would be supported in making decisions about their care plans.

All clinical staff 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).

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

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

All new patients who registered with the practice were offered a health check with the practice nurse within a week of registering. The GP was informed of all health concerns detected and these were followed-up in a timely manner. GPs told us they would use their contact with patient's to help maintain or improve mental, physical health and wellbeing. For example they would take a patients' blood pressure and on occasions have offered opportunistic smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 50% of patients in this age group took up the offer of the health check. The practice manager said they did not actively chase up the ones that did not attend, but would opportunistically discuss the check when patients attended the surgery for routine appointments.

The health care assistant had been trained to give advice on smoking cessation and the practice ran a weekly smoking cessation clinics. Information about the service was available in the waiting area. The service offered a 12 week programme to assist people in successfully stopping smoking. They however did not have any data to show how effective this had been.

Cervical screening was offered to woman in line with the national guidelines. The cervical screening uptake rate for women diagnosed with a mental illness whose notes record that a cervical screening test has been performed in the preceding 5 years was 100 percent and for the last QOF submission (April 2014) which was better than other GP practices in the Clinical Commissioning Group (CCG) area. Uptake for other women was 70%. The practice sent text message reminders for patients and would follow up patients who did not attend for cervical screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was approximately 70% which was average for the CCG, however the practice stated they were continually trying to improve their vaccination take up rates.

The practice met regularly with the CCG to discuss the implications and share information about the needs of the practice population. This information was used to help focus health promotion activity such as the need to provide more targeted information about cervical smears.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help as approximately two percent of patients were on a care plan which was reviewed on an annual basis. They practice kept a register of all patients with a learning disability and all 64 were offered an annual physical health check. Practice records showed 85% had received a check up in the last 12 months.

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, meningitis in children, flu and measles.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from April 2014 and a survey of patients undertaken by the practice's Patient Participation Group. (A selection of patients and practice staff who meet at regular intervals to decide ways of making a positive contribution to the services and facilities offered by the practice to the patients.) The evidence from both these sources showed patients were just satisfied with their experience at the practice. For example in their own patient survey 60% patients said they were satisfied with the practice and 54% people in the national patient survey said they would recommend the practice to someone else. However, in the national patient survey 47% rated their overall experience as very good and 44% rated it as fairly good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 57% of practice respondents saying the GP was good at listening to them and 54% saying the GP gave them enough time as compared to 40% and 42% respectively for the CCG.

All eleven patients we spoke with said they were treated with respect, dignity and compassion by all the practice staff and this was also reflected in the comment cards we reviewed. Patients said the care was excellent and staff were friendly, professional and accommodating. Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 39 completed cards and the majority were positive about the service experienced. Patients felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There was one comment that was less positive as they as they had to wait on occasions up to two weeks before they could see a doctor of their choice.

We observed staff to be caring, and compassionate towards patients attending the practice and when speaking to them on the telephone. 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 and was shielded by glass partitions which helped keep patient information private.

Staff told us that if they had never witnessed any instances of discriminatory behaviour or where patients' privacy and dignity had not been respected. They said there was a high proportion of their patients whose circumstances made them vulnerable such homeless people or people experiencing poor mental health, who often came to the surgery but the practice was clear about its zero tolerance for discrimination and made it clear to all patients. The lead GP told us they would investigate all such incidents and any learning identified would be shared with staff and patients. We saw the practice had arranged for staff to be trained in diversity and patient involvement.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice better than the CCG average however, the results were generally poor in these areas. For example, data from the national GP patient survey from July 2014 showed 38% of practice respondents said the GP involved them in care decisions and 51% felt the GP was good at explaining treatment and results compared to the national average of 32% and 40% respectively We were told this had been discussed at clinical meetings and all GPs had agreed to reflect and improve on this area in their consultations.

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 were given enough information to make informed decisions 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. We saw notices in the reception areas informing patients this service was available.

The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this feedback. For example, patients described how staff responded compassionately when they had been diagnosed with serious conditions and provided support when required.

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete carer's forms where appropriate and there was written information available for carers to ensure they understood the various avenues of support available to them.

There was a robust system of support for bereaved patients both provided by the GP's and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. This would then be followed by a visit at a flexible time and/or location to meet the family's needs. People were given the option to be referred for bereavement counselling or signposted to 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.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice worked closely with the palliative care nursing team and held quarterly meetings with them. Deaths of patients were discussed at the monthly practice team meetings.

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 the needs of their local population. When we inspected the practice was in the process of carrying out data extraction which was being used to populate a risk stratification tool (BIRT2) designed to identify patients at highest risk of attending A&E or being admitted to hospital, and also to enable the GPs to have peer to peer discussions regarding patients with similar health concerns. The BIRT2 risk tool helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice attended a monthly network meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan 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 as 61% of the patients fell into the index of high multiple deprivation and were from communities who were more at risk of conditions such as diabetes, COPD, alcohol dependency and lack of adequate physical fitness.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease, substance dependency and mental health.

Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly particularly frail older patients. The practitioner nurse was based at the practice carried out spirometry tests and liaised regularly with the GP that managed the care of patients diagnosed with chronic obstructive pulmonary disease (COPD).

One partner GP carried out home visits to a local forensic mental health care home when required. They told us they carried out physical health checks and medication reviews for people in the care home who were reluctant to visit the surgery. The senior GP also attended monthly multi-disciplinary team meetings to review and update these patients care plans. Patients who experienced poor mental health were kept on a register and invited for annual reviews with extended appointments. Reception staff we spoke with were aware of signs to recognise for patients in crisis and to have them urgently assessed by a GP if they presented at the practice.

The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed.

Four GPs had completed parts one and two of the Royal College for General Practitioners (RCGP) Alcohol Misuse certificate. This meant they were able to prescribe methadone to patients at the practice. The practice also had access to a counselling service which was situated in the same building where they could refer patients for drug and alcohol counselling.

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). For example, they had changed the appointment system to make more daily appointments available.

Tackling inequity and promoting equality

We were told by staff that a high proportion of the practice population did not speak English as their first language. The practice used a telephone translation service and had access to a Somalian interpreter who was– based in the building and employed by the CCG. This post was however vacant on the day of our inspection, however the CCG were in the process of recruiting. One GP was also trained in sign language.

The premises were accessible to patients with disabilities, although it was based on the first floor there was lift access to the first floor and the toilets were accessible to wheelchair users. The corridors were wide enough to accommodate mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

We saw that the practice had recognised the need for equality and diversity training for its staff and had included it the training plan for all staff for the coming year (2014-15). Staff we spoke with confirmed that they had had discussions in practice meetings about equality and diversity issues and that it was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 8.00am to 6.30pm Mondays, Wednesday, Thursday and Fridays. The practice had extended opening hours on Tuesdays 7.00am to 7.30pm and was particularly useful to patients with work commitments. The telephones were manned from 8.00am to 6.30pm Mondays to Fridays and a recorded message was available at all other times. Appointment slots were available throughout the opening hours, except between 12.30 and 1.30 daily, when the practice was closed for lunch although patients could attend specialist services or see the nurse during the lunch hour. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse

Comprehensive information was available to patients about appointments on the practice website which allowed patients to book appointments and home visits, order repeat prescriptions and access test results. Information was displayed in the practice waiting room and on the website directing patients to the NHS 111 out of hour's service when the practice was closed. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hour's service was also provided to patients in the practice information leaflet.

Patients were generally satisfied with the appointments system. 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. All patients we spoke with told us they had always been able to get an emergency appointment and if they had not been able to see the doctor the same day, they said they were able to talk with them on the phone.

The practice also had access to Kingsbury Hub, which was a backup service staffed by a nurse practitioner and locum GPs and contracted by the CCG. The Hub provided emergency GP services six days a week to patients from a number of practices in Brent and it was based in the same building as the practice. We saw that approximately 55 people a month had been referred to the Hub.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice's complaints policy and procedure were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. There was also information about how to contact other organisations such as NHS England to make a complaint displayed on the walls. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last twelve months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging. However, we saw the response to written complaints was not always in writing.

The practice kept a complaints log and we were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all staff.

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. Details of the vision and practice values were part of the practice's annual business plan and on their website. The practice vision and values included 'to treat all their patients with kindness, compassion, consideration, confidentiality and respect, provide an effective service of health education and illness prevention and to be aware of patient's family and social networks and their vulnerability."
- We spoke with nine 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 away day held in 2014 and saw that the vision and values had been reviewed and updated.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We saw that staff had completed a cover sheet to confirm that they had read the key policies such as safeguarding, health and safety and infection control. All seven policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly governance meetings which were attended by the partners, the practice manager and the senior administrator on occasions. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above national standards. They had scored 999 out 1000 in 2013 and 888 out of 900 in 2014, which was 5.8% above the CCG average and 5.5% above England average There was a clinical lead for the different areas of the QOF and we saw an action plan had been produced to maintain or improve outcomes. We saw QOF data was regularly reviewed and discussed at the practices monthly meetings.

The practice took part in a peer reviewing system with neighbouring GP practices form Kingsbury and Willesden. We looked at notes and saw that they met quarterly and discussed topics such as collaboration, pathways and joint funding applications for specialist services such as phlebotomy. It was also an opportunity for practices to work together to develop services focused on the needs of the local population for example nursing homes and residential care.

The practice had completed a number of clinical audit cycles, for example we saw an audit designed to identify patients having had exacerbations of COPD or Asthma and ensuring that all patients who had experienced an exacerbation were (i) invited for a chronic disease review and (ii) had a review of their medication. The re-audit showed an increase in the numbers of medication reviews and chronic disease reviews.

The practice had robust arrangements in place for identifying, recording and managing risks. Identified risks were included on a risk matrix maintained by the practice manager which graded risks as low, moderate, high and extreme. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk. We saw that the risk matrix was regularly discussed at team meetings and updated in a timely way.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there were GP leads for infection control, safeguarding and mental health. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that they 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, every six weeks. 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. They felt they worked well together and that they were a highly functional team which listened and learnt, and were aware of their areas of weakness such as the need to improve their flu vaccination take up. Staff said the leadership team were always open to suggestions. Team away days were held annually.

Are services well-led?

Good

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, For example, the recruitment and qualification checking procedure. We were shown the staff handbook which was available to all staff. This 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 an active patient participation group (PPG) which met quarterly. Information about the PPG was available on the practice website and in the practice newsletter. The PPGincluded representatives from various population groups including, older people, carers and patients from different ethnic and cultural backgrounds. However, the practice recognised that the group was not representative of the practices patients or example there were no young people, and had tried a number of ways to increase the membership. We were told by members of the PPG that they had specifically sought the views of young people and mothers in their latest survey. We saw that they had clear written objectives that were distributed to members. Meetings were held quarterly and one GP and the practice manager attended. We were given minutes of the last meeting dated 9/10/14 and saw that they had discussed nursing services, new practice services and flu vaccinations. However, we were told minutes were not routinely distributed to members but were displayed on notice boards at the practice and placed on their website. We met with 10 members of the PPG who were very enthusiastic and knowledgeable of the pressure in the NHS and primary care as two members also represented the practice at the CCG locality PPG meetings.

The practice had gathered feedback from patients through PPG patient surveys, comment cards and complaints received. We looked at the results of the in-house annual patient survey and saw that one area looked at was access to appointments. The results showed a number of patients were not aware they could book appointments on-line. Website data showed that whilst there had been thousands of hits over a six month period not many people had booked appointments on-line. Information gathered from the survey implied people were either not aware you could book online or found it difficult to book appointments using the website and by the time they worked it out all appointments had gone. We saw that as a result the practice had decided to provide more information about how to book on-line and make more daily appointments available. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff via staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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. Staff we spoke with were aware of the policy and the process to follow if they had any concerns

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. They had the opportunity to feedback on how useful the induction period had been. We looked at five staff files and saw that appraisals had taken place. Appraisals included a personal development plan and staff told us that the practice was very supportive of training.

The GPs and clinical staff held regular clinical meetings where they discussed changes to practice. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. For example we saw that the local cancer commissioning team had worked with the practice with a view to improving early referral rates for suspected cancer. We were told these types of sessions encouraged clinical debate, improved clinical management and guided service improvements.

A GP from the practice was also a program director at one of the local acute hospitals. The practice had recently approved as a training practice and will start taking trainee doctors in 2015. In addition we were told that medical students were currently being taught in the practice on Thursday mornings by the senior partners.

Are services well-led?

Good

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

The practice scheduled meetings for the whole staff team, clinical, non-clinical and operations management regularly. Staff were encouraged to attend various staff meetings and we saw from the minutes of meetings that they discussed where improvements to the service could be made.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings and away days to ensure the practice improved outcomes for patients. For example following an incident where a vulnerable patient was discharged from hospital it was discussed in a practice meeting and a process of following up hospital admissions for people subject to care plans had been established.