Blessing Medical Centre

Quality Report

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Date of inspection visit: 11th March 2015
Date of publication: 20/08/2015

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?	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Blessing Medical centre on 11 March 2015.

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 required improvement to be made to ensure they provide safe 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.

Our key findings were as follows:

- 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 guidance.
- We saw from our observations and heard from patients that they were treated with dignity and respect and all practice staff were compassionate.
- The practice understood the needs of their patients and was responsive to them. There was evidence of continuity of care and vulnerable patients were able to get urgent appointments on the same day.
- There was a culture of learning and staff felt supported and could give feedback and discuss any concerns or issues with colleagues and management

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

- The practice need to review its recruitment policy to ensure it is clear about which staff will be DBS checked and why.
- The practice should ensure all PGDs are signed by the GP.
- The practice nurse should attend training regarding Gillick competency.

Summary of findings

- The practice should provide equality and diversity training for its staff.
- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.

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. A slot for significant events was on the monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually.

All staff had received child protection training and although non-clinical staff had not received adult safeguarding training, the non-clinical staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults and were clear about how to report concerns. Administration staff who had not had a criminal records checked or risk assessed, had been asked to carry out chaperone duties without appropriate training, however staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination.

The practice had a defibrillator, but there was no evidence to confirm this was checked regularly and there was no oxygen cylinder on site at the time of our inspection.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were about 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 staff. There was evidence of multidisciplinary working to discuss the needs of complex patients especially those on integrated care plans. These meetings were attended by district nurses, community matrons, care coordinators 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

Summary of findings

vaccinations in line with current national guidance. There were systems in place for carrying out clinical audit cycles and evidence that completed audits were used to drive improvement in patient outcomes.

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 respect, dignity and compassion 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.

We saw that staff treated patients with kindness and compassion ensuring confidentiality was maintained. Patients told us the care was excellent and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback from the CQC patient comment cards we received was also positive and aligned with these views. Clinicians told us they would make phone calls to families who had suffered bereavement, offer to refer them to their in-house counsellor for support and attended some funerals of their patients.

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 Clinical Commissioning Group (CCG) to secure service improvements where these were identified. 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. 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 when needed. Premises were accessible to patients with disabilities as the surgery was on the ground floor. Toilets were accessible to wheelchair users.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. Although there was a need for a clearly documented vision which all staff were aware of, the staff felt the vision was to deliver high quality care, promote good outcomes for patients and continually strive to make improvements. however this was not documented.

High standards were promoted and owned by all practice staff and teams worked together across all roles. There were governance arrangements in place. Staff felt supported by management who had a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients and that there was a culture of learning.

The practice gathered feedback from patients through an internal patient survey organised by their patient participation group (PPG), who met quarterly and we saw changes made as a result of feedback from this group.

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

All patients over 75 years had a named GP to co-ordinate their care. The practice kept a register of elderly patients whose care needed to be prioritised and they made up approximately 2% of the practice population and all had care plans which were completed with the GP's during face to face consultations. We saw carers were often involved in drafting the care plans. The GP told us they would encourage these patients to keep as active as possible and often refer them to local support groups. Older patients have been given a different telephone number to contact then practice to make it easier for them to get through to the practice. There were also alerts written in patient's notes to ensure that the reception team offer these patients appointments with a GP or nurse on the same day.

People with long term conditions

Good

The practice had a high prevalence of diabetes (5%). The Intelligence Monitoring Report showed that in 2013/14, the percentage of diabetic patients whose HBA1C was stable was 62%. As of the 1st of March 2015, it had become 75%. The GP told us this was achieved by improving recalling patients to attend for blood tests as well as additional training in Diabetes for staff. They also actively sought support from the local diabetic specialist community service which was set up in Brent in 2014. The practice now runs joint diabetic clinics with a specialist diabetic nurse or consultant from the service in attendance. Patients with poorly controlled diabetes were invited to this clinic in order to optimise their diabetic control. In addition, the practice nurse regularly undertakes reviews for Asthma, chronic obstructive pulmonary disease (COPD) and hypertension

Families, children and young people

Good

The practice ran a weekly mother and baby and baby immunisation clinics which provided an opportunity for mothers to express any concerns to the GP or nurse. Staff felt these clinics also provided the opportunity for mothers to meet other mothers with young families for peer support. The practice offered appointments on the day for all children under 5's when their parent requests the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they actively promote sexual health advice and provides screening for chlamydia to young people and provide free condoms to patients on request. However, the nurse was not aware of Gillick competency.

Summary of findings

All members of staff undertake safeguarding children training to ensure that they are up to date with current protocols. The practice had set up a 'child protection' register as well as a 'child at risk' register. These registers were discussed regularly at clinical meetings. The practice also liaised with the local health visitor when they have any concerns about particular children.

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 child immunisations at age 12 months was approximately 70% which was similar to other practices in the CCG area.

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. Clinicians offered family planning advice, fitted IUDs and prescribed the contraceptive pill.

Working age people (including those recently retired and students)

Good

The practice offered an extensive range of health promotion and invited patients over 40 years of age to have an NHS health check. The practice offers working aged patients access to extended appointments on a Wednesday to 8pm. Patients could also make on-line appointments, order prescriptions and to get test results. They also offered phone consultations with the GP or the nurse for patients who could not attend the surgery.

People whose circumstances may make them vulnerable

Good

The practice has a vulnerable adult register to record patients who are vulnerable. Examples of such individuals are those who have learning disabilities, severe mental health illnesses or a history of domestic violence. These patients are discussed at clinical meetings to ensure that their needs are identified. Staff had a list of vulnerable patients to ensure they were prioritised for appointments. 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

Patients with diagnoses mental health illness at the surgery was (2.8%). The practice had CBT therapists and counsellors based there three times a week to support patients experiencing poor mental health and supports patient with conditions such as depression and anxiety.

QOF data showed the practice had scored 100% for conditions commonly found amongst older people such as dementia and 71% for mental health.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection and received 24 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were 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. Patients said the care was good and staff were friendly, professional and accommodating and that all staff treated them with dignity and respect.

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 partner GPs gave consistently good care. The national GP patient survey found that 79% of respondents described their overall experience of the practice as good and 71% said that they would recommend the practice to someone new.

Areas for improvement

Action the service SHOULD take to improve

- The practice need to review its recruitment policy to ensure it is clear about which staff will be DBS checked and why.
- The practice should ensure all PGDs are signed by the GP.
- The practice nurse should attend training regarding Gillick competency.
- The practice should provide equality and diversity training for its staff
- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.

Blessing Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GP's who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to Blessing Medical Centre

Blessing Medical Centre provides GP primary care services to approximately 2,200 people living in the Kilburn area of Brent. The practice is staffed by two GPs, one male and one female, a nurse, a practice manager and three administrative staff. The practice is owned by the practice manager and one of the GPs. They hold a General Medical Services (GMS) contract and are commissioned by NHSE London. The practice is 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 are 8.30am to 6pm Monday, Tuesday and Fridays, 8.30am to 6pm on Wednesday and 8.30am to 1pm on Thursday. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provides a wide range of services including clinics for diabetes, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provides health promotion services including a flu vaccination programme, travel vaccinations and cervical screening.

The practice is located in an area where the population is relatively young with 23% residents under 20 years of age and 70% are under 45 years of age. The population is ethnically diverse and overall 60% are from a black or ethnic minority group.

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, 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

Detailed findings

- 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 on 11th March 2015. During our visit we spoke with a range of staff (doctors, practice manager and administrative staff.) and spoke with patients who used the service. We reviewed policies and procedures, patient treatment 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

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw that they had recently discussed the issue of members of the public coming in to the practice to use the toilet which was located next to treatment rooms. This had been reported by members of administration staff as they felt it was putting both staff and patients at risk. The practice installed an interconnecting locking door between the waiting room and consultation rooms.

We reviewed safety records, incident reports and minutes of meetings from August 2013 where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the past year and saw this system was followed appropriately. Significant event analysis (SEA) SEA's were discussed with all staff at the monthly practice meetings. We saw evidence to confirm that the practice completed a SEA annually which included identifying any learning from the incident. and a dedicated meeting was held six monthly to review actions from past significant events and complaints. All staff were encouraged to log any significant event or incident and we saw there was a template for this that was accessible on all computer desk tops. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared for example when a patient had become aggressive and took their frustrations out on the administration staff. This was due to the GP telling them they were unable to treat them so asked them to rebook as their appointment should have been with a nurse, The learning point was that the administrative staff need to ask people why the want to make an appointment to ensure they saw the most appropriate clinician.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with told us of a recent alert they had discussed that had been circulated by the CCG regarding being alert to female circumcision. They also told us that alerts were discussed at monthly 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 was trained to either level one or level two. 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 and vulnerable adults. 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 located in safeguarding intranet pages and displayed on the walls of the treatment rooms and in reception. Since our inspection we have received evidence to confirm all staff have now completed safeguarding adults training.

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. The lead safeguarding GP was aware of all the vulnerable children and adults, and records demonstrated good liaison with partner agencies such as the police and social services. The safeguarding lead attended child protection case conferences and reviews where appropriate and reports were sent if staff were unable to attend.

All members of staff undertake safeguarding children training to ensure that they are up to date with current protocols. The practice has set up a 'child protection' register as well as a 'child at risk' register. These registers were discussed regularly at clinical meetings. The practice also liaises with the local health visitor when they have any concerns about particular children.

We saw evidence that the practice responds to Multi-Agency Safeguarding Hub (MASH requests promptly in order to help other agencies with enquires about vulnerable children. There were 7 patients on the child protection register and 10 patients coded as vulnerable children at risk.

A chaperone policy was in place and there were visible notices 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, they had not had Disclosure and Barring Service (DBS) checks carried out and no risk assessments had been undertaken. Staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. Since our inspection we have received information to confirm that all staff with chaperone duties have now been DBS checked and have received appropriate training.

Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

Medicines were stored in medicine refrigerators in the nurse's treatment room. 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 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 nurse 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 room. The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

We were told the nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw the nurse kept all PGDs in a folder; however the most recent ones had not been signed by the GP. The lead GP told us they would address this immediately after the inspection. We saw evidence that nurse had received appropriate training and been assessed as competent to administer the medicines referred to under the PGDs.

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

No controlled drugs were kept at the practice.

Requires improvement

Are services safe?

Cleanliness and infection control

We observed the premises were clean and tidy on the day of our inspection. Cleaning of the premises was carried out five days per week by a contract cleaner that was employed by the practice. Cleaning records were kept which showed a list of what had been cleaned at each visit. Reception staff told us that 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. Staff we spoke with had received training on infection control, however we noted it was not part of the mandatory training for staff. An infection control audit had been carried out in August 2014 which had identified the need to have clear information displayed in consultation rooms about sharps disposal and alcohol hand sanitizer available in the waiting room. We saw that both had been actioned. 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.

Although 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), a legionella test had not been carried out. Since our inspection we have received information to confirm that water tests were completed on 14th April 2015 and no concerns regarding risk of infection to staff and patients were identified.

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. However, on the day of our inspection we noted that portable electrical equipment testing (PAT) was last carried out in August 2013. Since our inspection we have received information to confirm that all equipment was PAT tested in April 2015. A schedule of testing is now in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in August 2014.

Staffing and recruitment

The practice had a recruitment policy in place which was up-to-date. However, we noted there was no mention of carrying out criminal records checks via the Disclosure and Barring Service for any staff. We looked at a sample of recruitment files for GPs, administrative staff and nurses and found they contained proof of identification, references, qualifications and registration with the appropriate professional body. At the time of our inspection no criminal records checks had been undertaken for any staff, however since out inspection we have received information to confirm that all staff have had the checks carried out.

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 practice manager occasionally provided cover in reception during busy periods.

The GP partner 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.

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 quarterly 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. The practice manager was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk log maintained by the practice manager with clear actions required and date to be completed clearly noted. We saw that any risks were discussed at practice meetings.

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 these patients had not attended for tests.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The practice had an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and all staff had been trained to use it. All staff asked knew the location of this equipment. We saw records to confirm they were checked regularly. The practice did not have an oxygen cylinder available, however since our inspection we have received evidence to confirm that one has now been purchased.

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 in the nurses' treatment room 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 utility suppliers, all staff contact numbers and email addresses and contact details for locum doctors. The plan was reviewed on an annual basis.

A fire risk assessment had been undertaken in February 2015 and we saw that it included checks to fire alarms test and fire drill records which had been carried out weekly and quarterly respectively. We saw records to confirm that staff were up to date with fire training.

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 monthly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. Clinical concerns were also discussed at the partner's weekly meetings for cases that could not wait until the monthly meeting was held. The GPs and nurse told us staff completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

The partner GP was the lead for specialist clinical areas such as diabetes, heart disease, and chronic obstructive pulmonary disease (COPD). The practice nurse also had additional training in diabetes and facilitated weekly diabetes clinic which was attended on occasions by the diabetes consultant from the local hospital. GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. 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.

The practice actively monitored their referrals to secondary care; practice data is reconciled with the hospital data and outcomes are reviewed at quarterly peers meeting. We saw the practices referral rates were similar to other practices in the area and within the CCG guidance level.

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 four clinical audits that had been undertaken in the last year. Three of these were completed audits i.e. the practice had re-audited. The practice was able to demonstrate the resulting changes since the initial audit. 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 designed to identify patients who have had the dose of steroid inhalers increased following exacerbations of Asthma symptoms. 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 that there were a number of patients who had not been reviewed annually and had continued to be prescribed high dose steroid inhalers when they should have been prescribed lower doses after their exacerbated symptoms had reduced. The audit also showed that there were some patients who were no longer requesting their high dose inhalers, and therefore required a medication review. The outcome of the audit resulted in a decrease in prescriptions for inhalers, specifically for children.

GPs told us they were committed to maintaining and improving outcomes for patients. The QOF report from 2012-2013 showed the practice scored 662 out of 1000. QOF information for 2013-2014 indicated the practice had improved scoring 770 out of 900. Clinical staff spoke positively about the culture in the practice around quality improvement and we saw they had produced an action plan to address the QOF areas of concern.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP's. 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

Good

Are services effective?

(for example, treatment is effective)

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.

Practice representatives attend monthly locality CCG meetings to feedback on areas where there is an increase in the trend for referrals and/or areas of increased spends for prescribing. This benchmarking data showed the practice had outcomes that were similar to other services in the area for prescribing.

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. 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 General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.)

The staff induction programme covered a range of topics such as basic lifesaving support, child protection and health and 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 both develop them and ensure they had the knowledge and skills required to carry out their roles. For example, the practice nurse had attended COPD, Asthma and health check training. The practice had a locum induction pack and checklist available for GP locums used to provide cover.

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. All staff received annual appraisals which identified learning needs. Non-clinical staff were appraised by the practice manager and clinical staff were appraised by the GP partners. Staff records demonstrated that appraisals were up to date. 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 medication for those experiencing poor mental health.

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 NHS 111 advice service 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 administrators circulated the documents and results to the relevant GPs who were responsible to carry out the action required. All staff we spoke with understood their roles and felt the system in place worked well. We were told there were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice attended monthly integrated care meetings to discuss the needs of complex patients e.g. those with end of life care needs. These meetings were attended by community matrons, 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 GPs told us that they would often have ad hoc discussions outside of these meetings 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

Good

Are services effective?

(for example, treatment is effective)

manner. An electronic system was also in place for making referrals for tests or to see specialists and staff 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.

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 might use it in their practice. For example, one GP told us they would apply the Act if they had concerns about an older person with Dementia in relation to 'end of life' care arrangements.

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. We saw the practice had scored 100% for learning disabilities in their last QOF submission.

Both GP's 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). However, the practice nurse did not have an understanding of Gillick competency and we drew this to the attention of the lead GP who said they would arrange training.

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.

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 had offered opportunistic diet and nutrition advice.

The practice also offered NHS Health Checks to all patients aged 40-75 without a known chronic condition. Although take up was relatively low, 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.

A smoking cessation advisor from Brent council attended the practice monthly to run a clinic. GPs also told us they gave smoking cessation advice opportunistically when seeing patients.

Screening for breast, bowel and cervical cancer was offered in line with national standards. The practice performance for cervical smear uptake was 71% for 2013 - 2014 which was similar to other practices in the local CCG area, but lower than the national average of 81%. The practice told us that as of the 1st of March 2015 their uptake had increased to 77%. They said they improved their performance by actively inviting patients via SMS messaging and increasing the awareness of the importance of smear tests amongst the clinical and non-clinical staff.

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 child immunisations at age 12 months was approximately 70% which was similar to other practices in the CCG area.

A wide range of information was displayed in the waiting area 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 2014 and a survey of patients undertaken by the practice's Patient Participation Group (PPG). (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 satisfied with their experience at the practice. For example, 79% of patients who responded described their overall experience as good. The practice was also average for its satisfaction scores on consultations with doctors and nurses, with 85% of practice respondents saying the GP was good at listening to them and 88% saying the GP gave them enough time as compared to 85% and 85% respectively for the CCG.

We spoke with seven patients and all said they were treated with respect, dignity and compassion by all the practice staff. Patients said the care was good 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 24 completed cards and all were positive about the service experienced. Patients felt the practice offered a good service and staff were helpful, friendly, caring and took the time to explain everything. They said that all staff treated them with dignity and respect.

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 which helped keep patient information private.

Staff told us that they had never witnessed any instances of discriminatory behaviour or where patients' privacy and dignity had not been respected. They said there were some patients whose circumstances made them vulnerable such as 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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in this area. For example, data from the national GP patient survey from 2014 showed 89% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. 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.

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 with all GPs. They also told us they felt listened to and supported by all other 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.

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 a carer's forms where appropriate and there were written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

There was a robust system of support for bereaved patients both provided by the practice and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. 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. Deaths of patients were discussed at the monthly practice team meetings and staff would attend funerals on occasions.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised.

The partner GP was the lead for a variety of long term conditions including diabetes, asthma, chronic obstructive pulmonary disease, learning disabilities and mental health.

All patients over 75 years had a named GP to co-ordinate their care. They made up approximately 2% of the practice population and all had care plans which were completed with the GP's during face to face consultations. We saw carers were often involved in drafting the care plans. The GP told us they would encourage these patients to keep as active as possible and often refer them to local support groups. Older patients have been given a different telephone number to contact then practice to make it easier for them to get through to the practice. There were also alerts written in patient's notes to ensure that the reception team offer these patients appointments with a GP or nurse on the same day.

The practice had a high prevalence of patients with diabetes (5%). The Intelligence Monitoring Report showed that in 2013/14, the percentage of patients with diabetes whose HBA1C was under 64mmol/mol was 62%. As of the 1st of March 2015, it had become 75%. The GP told us this was achieved by improving recalling patients to attend for blood tests as well as additional training in Diabetes for staff. They also actively sought support from the local diabetic specialist community service that was set up in Brent in 2014. The practice now runs joint diabetic clinics with a specialist diabetic nurse or consultant from the service in attendance. Patients with poorly controlled diabetes were invited to this clinic in order to optimise their diabetic control. In addition, the practice nurse regularly undertakes reviews for Asthma, COPD and hypertension.

The practice ran a weekly mother and baby and baby immunisation clinics which provided an opportunity for mothers to express any concerns to the GP or nurse that they may have. Staff felt these clinics also provided the opportunity for mothers to meet other mothers with young families for peer support. The practice offered appointments on the day for all children under 5's when their parent requests the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they actively promote sexual health advice and provides screening for chlamydia to young people and provide free condoms to patients on request.

The practice offered working aged patients access to extended appointments on a Wednesday to 8pm. They also offered on-line appointments, online ordering of repeat prescriptions, and telephone consultations to speak with the GP or nurse and to get test results.

The prevalence of mental health illness at the surgery was high (2.8%). The practice had Cognitive Behavioural therapist CBT therapists and counsellors based there three times a week to support patients experiencing poor mental health and supports patient with conditions such as depression and anxiety.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises were accessible to patients with disabilities 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.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice did not provide equality and diversity training for its staff, however 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 8.30am to 6.00pm Mondays, Tuesday, Thursday and Fridays. The practice had extended opening hours on Wednesday to 8.00pm which was particularly useful to patients with work commitments. The telephones were manned from 8.00am to 6.00pm Mondays to Fridays excluding Wednesday when they were answered up to 7pm, a recorded message was available at all other times. Appointment slots were available throughout the opening hours, except between 1pm and 2pm 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.

The practice also had access to Kilburn GP 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 seven days a week to patients from a number of practices in Brent. We saw that approximately 18 people a month were referred to the Hub.

Comprehensive information was available to patients about appointments on the practice website which allowed patients to book appointments and home visits and order repeat prescriptions. Information was displayed in the practice waiting room and on the website directing patients to the Kilburn GP Hub and the 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 told us they were satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice. In these circumstances the practice would get patients to complete an 'Immediate treatment request form' on arrival. All patients we spoke with told us they had always been able to get an emergency appointment or talk with a GP on the phone.

Feedback from the national GP survey published in 2014 was positive about the appointment system. 81% of respondents described their experience of making an appointment as good and 83% were satisfied with the surgery's opening hours. Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment stating they could always get an appointment when needed.

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. 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 lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, we saw that where a patient had complained about not getting their repeat medication on time the practice investigated and found there had been issues with the automatic repeat prescription system. A review was carried out and a procedure implemented to ensure both the practice and the chemist refreshed their system regularly.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice kept a complaints log and also held a quarterly complaints meeting attended by the partners. 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 lead GP told us their vision was to deliver a high standard of patient care and be committed to patient needs however this was not documented in the form of a mission statement as the GP had only recently become a partner. Staff we spoke felt the vision was to deliver high quality care, promote good outcomes for patients and continually strive to make improvements. We found staff were clear about their responsibilities in relation to providing good care at the practice.

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. Staff we spoke with confirmed they had read the key policies such as safeguarding, health and safety and infection control. All six 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. 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 below national standards. They had scored 770 out of 900 in 2014, which was 7.3% below the CCG average and 7.9% below England average. However, the lead GP and the nurse were clinical leads for the different areas of the QOF and we saw an action plan had been produced to 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 from Brent. We looked at notes and saw that they met quarterly and discussed topics such as collaboration and referral pathways. It was also an opportunity for practices to work together to develop services focused on the needs of the local population for example services for people with diabetes.

The practice had completed a number of clinical audit cycles, for example we saw an audit designed to identify patients having had exacerbations Asthma where the dose of steroid inhalers were increased when patients have exacerbations. All patients who had experienced an exacerbation were (i) invited for a chronic disease review and (ii) had a review of their medication. The audit showed that there were a number of patients who had not been reviewed annually and had continued to be prescribed high dose steroid inhalers when their dose should have been decreased when their symptoms stabilised. The outcome of the audit resulted in a decrease in prescriptions for inhalers, specifically for children.

The practice had robust arrangements in place for identifying, recording and managing risks.

Identified risks were included on a risk log maintained by the practice manager with clear actions required and date to be completed by clearly noted. We saw that the risks were 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 the GP partner was the lead for safeguarding and mental health and the nurse was the lead for infection control. We spoke with six 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 month. 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 contact with community mental health services. Staff said the leadership team were always open to suggestions. Team away days were held annually.

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.

Are services well-led?

Good

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

Practice seeks and acts on feedback from its patients, the 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. The PPG included representatives from various population groups including, older people, carers and patients from different ethnic and cultural backgrounds. The practice felt that the group was representative of the practices patients. Meetings were held quarterly and either a GP or the practice manager attended. We were shown minutes of meetings held in 2014 and saw that they had discussed having a TV in the waiting room showing health information and light entertainment. We were told minutes were distributed to members and displayed on notice boards in the waiting rooms on the website.

The practice had gathered feedback from patients through PPG patient surveys and complaints received. We looked at the results of the in-house annual patient survey from 2014 and saw that one area reviewed was patient's dissatisfaction with the length of time it took to get through on the telephone. As a result the practice had installed another telephone line and a number of patients we spoke with said the situation had improved.

Staff told us they could 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. We looked at staff files and saw that annual appraisals were up to date. Appraisals included a personal development plan and staff told us that the practice was very supportive of training. For example the nurse had attended training to improve outcomes for people with COPD and

leg ulcer management.

The practice scheduled meetings for the whole staff team, clinical and non-clinical. 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 to ensure the practice improved outcomes for patients. For example following an incident where members of the public were coming in to the practice to use the toilet, which presented risks to both staff and patients, the practice had installed an interconnecting locking door between the waiting room and consultation rooms.