Park Medical Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Park Medical Centre on 1 March 2016. Overall the practice is rated as Good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the practice had appointed a pharmacist who was responsible for the prescribing processes and carrying out reviews of long term condition (LTC) patients. Due to the success of the pilot the CCG agreed that five other local practices can implement similar posts and Park Medical Centre pharmacist was leading the recruitment.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, last year's survey had identified concerns about the time it takes to check in when the reception is busy. As a result the practice had installed an electronic checking in system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw some areas of outstanding practice including:

- In July 2014 the practice became responsible for a care home with 146 people. At the time of registration of

Summary of findings

these patients the GPs found very few had had end of life care planning (3%) or resuscitation decisions made (6%). At the time of our inspection we found 81% patients had care plans and 47% had resuscitation decisions, which had been agreed with the relatives and the nursing staff at the home.

- There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment and the practice took part in local pilot schemes to improve outcomes for patients in the area. For example, the practice had appointed a pharmacist who was responsible for the prescribing processes and carrying out reviews of LTC patients. We noted there were clear outcome measures in place to assess the impact and success of the pilot. Due to the success of the pilot the CCG had agreed that five other local practices had decided to implement similar posts and Park Medical Centre pharmacist was leading the recruitment for these practices. It was also agreed that they would also manage these pharmacists.

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

- The practice should consider purchasing a defibrillator or carry out an appropriate risk assessment.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed

Are services effective?

Good

The practice is rated good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice had developed clinical protocols so that the links to NICE and other bodies were embedded in clinical practice.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- The practice met with other local providers to share best practice.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

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

Are services responsive to people's needs?

Good

The practice is rated as good for being responsive.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. In July 2014 the practice became responsible for a care home with 146 people. At the time of registration of these patients the GPs found very few had had end of life care planning (3%) or resuscitation decisions made (6%). At the time of our inspection we found 81% patients had care plans and 47% had resuscitation decisions.
- There are innovative approaches to providing integrated patient-centred care. The practice pharmacist had been trained to perform duties required to monitor long term conditions such as Asthma, Diabetes, Common Obstructive Pulmonary Disease (COPD) and Hypertension.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. Last year's survey had identified concerns about the time it takes to check in when the reception is busy. As a result the practice had decided to install an electronic checking in system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led.

Summary of findings

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. There are consistently high levels of constructive staff engagement. The practice carried out team learning at the weekly meetings. For example, we saw the substance worker had provided training on alcohol awareness, The practice had also introduced annual Schwartz rounds which provided a structured forum where all staff got together to discuss the emotional and social aspects of working in healthcare.
- The practice gathered feedback from patients using new technology, and it had a very engaged patient participation group. They PPG carried at a number of activities to raise money for the practice, social services and local voluntary charities. We saw they had arranged a raffle for unwanted Christmas presents and had raised £800, which was used to purchase a swing for the local park.

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

Outstanding 

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

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. Patients over 75 years had a named GP to co-ordinate their care. They had identified that 4% of their older patients were at risk hospitalisation and were implementing care plans for these patients. Double appointments were available for these patients when required.
- In July 2014 the practice became responsible for a care home with 146 people. At the time of registration of these patients the GPs found very few had had end of life care planning (3%) or resuscitation decisions made (6%). At the time of our inspection we found 81% patients had care plans and 47% had resuscitation decisions, which had been agreed with the relatives and the nursing staff at the home.
- The practice utilised other support services, such as referring patients to a befriending service run by a local charity.
- The GPs had access to a Care of the Elderly Consultant for the Nursing Home patients

People with long term conditions

Good 

The practice is rated as good for the care of people with long-term conditions.

- The practice had clinical leads for a variety of long term conditions including diabetes and chronic obstructive pulmonary disease (COPD). We saw all clinical members had completed further training in their areas of responsibility and acted as a source of information for other staff. For example, the diabetes lead had recently trained to administer insulin.
- The practice pharmacist had been trained to perform duties required to monitor long term conditions such as Asthma, Diabetes, COPD and Hypertension. They carried out reviews for patients in these groups. Forty five GP face to face consultations were saved on a weekly basis. The health care staff had also been trained in spirometry.
- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs

Summary of findings

attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs.

- Services such as spirometry, phlebotomy, Ambulatory Blood Pressure Monitoring (ABPM) and anticoagulation management service were carried out at the practice

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. There was also a separate waiting area for families with young children to sit away from other patients so children could play.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- Reception staff had been trained in breast feeding awareness and an isolation bench was provided for women wishing to undertake breast feeding in private.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Pop up alerts were placed on all computer notes to alert all members of staff of vulnerable patients.
- Learning Disability patients were given care plans that met their needs. Patients with learning disabilities were invited annually for a specific review with their named GP. We saw all 42 patients on the register had reviews carried out in the last 12 months.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice had a relatively large amount of substance misuse patients and there were Drug and Alcohol workers attached to the practice three days per week, which allowed effective monitoring of these vulnerable patients. They worked in partnership with the lead GP who had the RCGP Certificate parts 1 and 2 in the management of drug misuse. Patients were reviewed on a regular rolling three month cycle.
- The alcohol recovery workers offered supported community-based alcohol detoxification for appropriate patients and local people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. We saw they would refer patients to other services such as Cognitive Behavioural Therapy (CBT).
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

- The practice carried out advance care planning for patients with dementia. All 146 patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average.
- The practice had a register of patients experiencing poor mental health. These patients were invited to attend annual physical health checks and all 146 had been reviewed in the last 12 months.
- They had mental health lead GP and there was a primary care mental health worker (PCMH) based at the practice one day a week whose role included supporting patients with mental illness transfer from secondary care back to primary care. There were monthly reviews of all patients being seen by the PCMH worker with the lead GP. Patients were also referred to other services such as IAPT (Improving Access to psychological therapies) for CBT and counselling.
- An IAPT therapist was based at the practice once a week.
- The practice based pharmacist also provided care for patients with mental health by carrying out medication reviews and also periodically checked that prescriptions had been picked up from the pharmacy and took appropriate action where they had not been.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. MIND had delivered training on the different forms of schizophrenia and the CCG dementia lead had provided dementia awareness training.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing below or in line with local and national averages. There were 108 responses and a response rate of 28%, which was 1.2% of the practice population.

- 56% found it easy to get through to this surgery by phone compared to a CCG average of 75% and a national average of 73%.
- 82% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average 83% and a national average 85%
- 83% of patients described the overall experience of this GP practice as good compared to a CCG average 84% and a national average 85%
- 72% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to a CCG average 78% and a national average 85% 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards which were all positive about the standard of care received. However, there were a number of comments about waiting three to four weeks to get a routine appointment with their named GP. Also there were a few comments about not being able to get through by phone first thing on a morning and their survey results supported this.

We spoke with five patients during the inspection. All said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, they also commented about the wait for a routine appointment.

We noted that 91% of patient who had completed the friends and families test said they would recommend the practice.

Park 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 a GP and another CQC inspector.

Background to Park Medical Centre

Park Medical Centre provides GP primary care services to approximately 9000 people living in Hammersmith and Fulham. The local area is a mixed community and there is a wide variation in the practice population, from relatively deprived to extremely affluent and mainly young to middle age.

The practice is staffed by six partners, one of whom is the practice manager. In addition there is one salaried GP and ther were in the process of recruiting another. There are two male GPs and four female GPs who work a combination of full and part time hours totalling 44 sessions. The practice is a training practice and employs three trainee GPs. Other staff included a practice pharmacist, two nurses, a health care assistant, two phlebotomists, a practice manager and seven administrative staff. The practice holds a General Medical Services (GMS) contract and was 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 was open from 8.30am to 6.30pm Mondays to Fridays, but was closed for lunch between 12.30pm and 1.30pm. They provide extended hours on a Thursday to 7pm, which was particularly useful to patients with work commitments. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP, a nurse and the practice pharmacist. Pre-bookable appointments could be booked up to three weeks in advance; urgent appointments were available for people that needed them. Patients could book appointments online.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting 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 1 March 2016. During our visit we:

- Spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service.
- Reviewed policies and procedures, records and various documentation
- Reviewed Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

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

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

Good

Are services safe?

Our findings

Safe track record

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 report all incidents to the practice manager. They said they would have an initial discussion and agree any initials actions that should be taken. The practice manager told us they would then ask the staff to go away and reflect on the incident and then complete the incident form located on the computer shared drive. Staff we spoke with were aware of their responsibilities to bring incidentsto the attention of the practice manager. They said they were always discussed at the weekly staff meetings. Minutes were also sent out to staff not present at these meetings.
- The practice carried out a thorough analysis of the significant events on a quarterly basis and sent annual reports to the CCG. They also discussed these at their monthly locality meetings with other practices where action taken and lessons learnt were circulated.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw where a patient had received some treatment and it was found that their records had not been updated at the time and as a result the patient had received a letter from the practice to come in for that same treatment. When this was brought to the practice attention they sent a letter of apology and reviewed their processes. They reminded all GPs to ensure that patient's records were updated and saved before the patient left the room.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. All staff had received relevant role specific training on safeguarding adults and children. Clinicians were trained to level 3 and non-clinicians level 1. All staff we spoke with knew how to recognise signs of abuse, they were also aware of their responsibilities and knew how to share information, record and document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located in intranet pages and displayed on the walls in reception and treatment rooms. Weekly child safeguarding meetings were held at the practice, which were attended by a health visitor and GPs from the practice. The lead GP attended all external safeguarding meetings.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If the practice nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role on occasions. The practice nurse provided chaperone training to the administrative staff members. All staff we spoke with understood their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff providing these duties had been Disclosure and Barring Service checked. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. The practice completed a

weekly infection control checklist and annual audits were undertaken. We saw evidence that action was taken to address any improvements identified as a result. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The practice pharmacist was responsible for handling repeat prescriptions which included the review of high risk medicines. They carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. The pharmacist had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The risk assessment forms graded risks as catastrophic, major, moderate, minor and insignificant. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Portable electrical equipment testing (PAT) had been carried out in August 2015. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, weighing scales and pulse oximeter which had been carried out in had been carried out at the same time.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw that where they had an increase in patient numbers, both clinical and non-clinical staff numbers had also been increased. The practice had looked at what particular skills were needed before staff recruitment was started. For example, we saw that when they registered the patients from the nursing home a high amount of these patients were on a combination of medications. The practice also reviewed the amount of patients with LTCs and their repeat prescribing processes. They therefore decided to employ another salaried GP and a practice pharmacist with prescribing qualifications, to manage the medication reviews and repeat prescriptions of all patients. 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 reception manager occasionally provided cover in reception during busy periods.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

Good

Are services safe?

- There was a panic alarm system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice did not have a defibrillator but had carried out a risk assessment which concluded that as an ambulance station was a few minutes from the practice and when called they could attend within a few minutes. However, they said they would review their decision. There was oxygen with adult and child masks available. There was also a first aid kit and accident book.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were held off site by the practice manager and GPs.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. 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 practice also developed clinical protocol links to these guidelines and referral pathways.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The practice pharmacist would email and discuss any drug alerts received, at the weekly clinical meeting. They also ran quarterly audits to find out if any patients were still taking any of the drugs on these alerts. All GPs would review 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 all clinicians had a good understanding of best treatment for each patient's needs.
- These patients would be discussed at the meetings with clear explanation documented if they were to remain on these drugs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available with 16% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). We were told that level of exception reporting was mainly due to their nursing home and other vulnerable and disabled patients who had multiple morbidities that either prevented QOF monitoring or made it inappropriate, for example palliative or BP in those with postural hypotension. However, they were reviewing their entire QOF process this year with a combination of earlier recall and increased scrutiny with particular input from their pharmacist.

This practice was not an outlier for any QOF (or other national) clinical targets. The QOF data showed:

- Performance for diabetes related indicators was 81% which was 2% below the CCG and 8% below the national average.
- Performance for mental health related indicators was 99% which was 13% above the CCG and 6% above the national average.

The practice had recognised that their performance was low for diabetes and the practice pharmacist had started seeing patients with type 2 diabetes, for medical reviews and a GP had trained to start patients on insulin. We saw that their current QOF diabetes score had improved.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes.

- There had been six clinical audits carried out in the last year. Two were completed where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, one GP had completed a duloxetine (a drug prescribed for conditions such as depression and diabetic pain) audit. The aim was to ensure that all patients in receipt of this medication were receiving it for a licensed reason and not for pain alone. The initial audit showed that 15 patients were in receipt of the medication. All patients were reviewed and on re-audit they found 11 patients were still taking it for the reason outlined by NICE. However of these five patients were referred to secondary care for further screening and six were being closely monitored.
- Opportunities to participate in local audits, national benchmarking, accreditation, peer review and research were proactively pursued. The practice attended a monthly locality meetings run by the CCG. Performance data from the practice was evaluated and compared to

Good

Are services effective?

(for example, treatment is effective)

similar surgeries in the area. Further, at the time of our inspection they were participating in a research project with the Imperial University called I-Hydrate, which was looking at how to ensure people in nursing homes got enough water.

The team made use of clinical audit tools and clinical meetings to improve performance. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved at their weekly clinical meetings. Staff spoke positively about the culture in the practice around audit and quality improvement.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety. The practice also had comprehensive induction packs for each role in the practice which were kept up to date.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff also completed regular mandatory courses such as annual basic life support and health and safety training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics.
- Staff told us that career development was a priority. They had access to additional training to ensure they had the knowledge and skills required to carry out their roles and staff were proactively supported to acquire new skills and share best practice. For example, receptionists had been trained to be phlebotomists, healthcare assistants and the carers lead for the practice. The healthcare assistants were also being trained to carry out spirometry and Ambulatory Blood Pressure Monitoring (ABPM).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and test results.
- All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw they were participating in an Integrated Care pilot with the community nursing teams and other practices in the CCG. GPs told us this had improved communication and sharing of relevant information and had reduced duplication and confusion for patients, carers and staff. All patients had care plans which they had been involved in drafting. They included information about how to manage their conditions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. The district nursing team and health visitors were based in the same building and would ad hoc discussions with the GPs when they had serious concerns about patients.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.
- There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical

Good

Are services effective?

(for example, treatment is effective)

procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this.

- The practice also documented in patients notes if they had refused a chaperone when offered.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. There was an in-house smoking cessation service and patients were signposted to other the relevant service.
- Drug and alcohol workers, a mental health support worker and IAPT therapists were available at the practice three days a week to provide additional support to patients.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%. The practice nurse told us they would contact women directly by letter and send text message reminders for patients and would follow up patients who did not attend for cervical screening.

Childhood immunisation rates for the vaccinations given were better than the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69% to 87% and five year olds from 73% to 97%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

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, fever in children and influenza. There was also information about local health and community resources.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The reception desk and waiting area were widely separated, which allowed patients to have conversations that could not be overheard from the waiting room.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The 35 patient CQC comment cards we received were positive about the service experienced. We also spoke with five patients on the day of the inspection and two members of the patient participation group. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were satisfied with the care provided by the practice. However, some comment cards and patients we spoke with were concerned about the time it took to get a routine appointment; they said it could take three to four weeks if they wanted to see a specific doctor.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2015, the practices internal patient survey and the results from the NHS Friends and Family Test where 91% patients said they would recommend this practice.

Results from the national GP patient survey showed the practice was comparable with the local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% said the GP was good at listening to them which was in line with the CCG average of 87% and national average of 89%.
- 84% said the GP gave them enough time which was in line with the CCG average of 84% and national average 87%.
- 98% said they had confidence and trust in the last GP they saw which was above the CCG average 95% and national average 95%.
- 83% said the last GP they spoke to was good at treating them with care and concern which was comparable with the CCG average 84% and national average 85%.
- 86% said the last nurse they spoke to was good at treating them with care and concern which was comparable with the CCG average 85% and national average 90%).
- 85% said they found the receptionists at the practice helpful which was comparable with the CCG average 85% and national average 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that 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.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 76% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average 79% and national average 81%.

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 and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations, including counselling, cancer support and bereavement

Good

Are services caring?

services. The practice's website gave listing of all the support available in the GP surgery including carer services and mental health support, which could be accessed through self or GP referral.

One of the practice admin team was the carers lead. They had attended additional training to help them implement appropriate systems for identifying and supporting patients with caring responsibilities. They had attended meetings with other practices, facilitated by Carers UK, to discuss challenges and arrange joint carer's events such as a monthly Saturday café at the local church. These sessions helped people complete carer's assessments and discuss what it meant to be a carer. The practice's computer system alerted GPs if a patient was also a carer. Patients with caring responsibilities were encouraged to identify themselves to the practice team so that they could be offered additional support if they needed it. The practice had identified 100 carers (over 1% of the patient list) to date, including three young carers (under 19) who had been referred to the 'Young Carers Network'. Written information was available to direct carers to the various avenues of support available to them. We also noted the practice had a carer's information event at the practice in 2015.

Staff told us that if families had suffered bereavement, their usual GP contacted them by phone and some would send a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

For example 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 such as local referral pathways for diabetes patients and prescribing.

- Patients over 75 years had a named GP to co-ordinate their care. Double appointments were available for these patients when required. They had identified that 4% of their older patients were at risk and were implementing care plans for these patients. In July 2014 the practice became responsible for a care home with 146 people. The home had five floors and the practice provided weekly ward rounds - one floor every day, which meant there was a GP on site every day. At the time of registration of these patients the GPs found very few had had end of life care planning (3%) or resuscitation decisions made (6%). At the time of our inspection we found 81% patients had care plans and 47% had resuscitation decisions, which had been agreed with the relatives and the nursing staff at the home. The GPs told us they had started with the most frail and elderly patients. The practice utilised other support services, such as referring patients to a befriending service run by a local charity and a geriatric consultant attended the home once a week.
- The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. We saw all clinical members had completed further training in their areas of responsibility and acted as a source of information for other staff. For example, the diabetes lead recently trained to initiate insulin therapy for Type 1 diabetics. 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 and consultants on occasions, 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. The practice pharmacist had been trained to perform duties required to monitor long term conditions such as Asthma, Diabetes, COPD and Hypertension. They carried out reviews for patients in these groups. 35 face to face and 30 telephone consultation were saved on a weekly basis, therefore reducing demand on time of other clinicians The health care staff had also been trained in spirometry. This was to respond to their low prevalence of COPD within the practice. Reception staff supported clinicians in ensuring annual reviews were completed for all patients. Services such as spirometry, phlebotomy, ABPM and anticoagulation management service were carried out at the practice.
- The practice held weekly baby clinics and there were systems in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, they would refer families for additional support and had multidisciplinary meetings with health visitors where any safeguarding concerns would be discussed. The practice triaged all requests for appointments on the day for children when their parent requested the child be seen for urgent medical matters, thus were able to offer appointments at a mutually convenient times, for example after school, when appropriate. Reception staff had been trained in breast feeding awareness and an isolation bench was provided for women wishing to undertake breast feeding in private. There was also a separate waiting area for families with young children to sit away from other patients so children could play. The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening.
- The practice offered working age patients access to extended appointments once a week and had access to weekend and evening appointments at another local practice. They offered on-line services which included appointment management, viewing patient records, repeat prescriptions and registration. They also had GP telephone triage for all requests for same day appointments, which enabled telephone consultations where appropriate, without patients having to take time off work.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The GPs told us that patients whose circumstances may make them vulnerable such as people with learning disabilities and substance misuse patients were coded on appropriate registers. Pop up alerts were placed on all computer notes to alert all members of staff of vulnerable patients. GPs told us this was to allow them to meet their specific additional needs such as double appointments, interpreter, visual/hearing impaired, carer details, and risk assessment stratification. Learning Disability patients were given care plans that met their needs. Patients with learning disabilities were invited annually for a specific review with their named GP. We saw 100% of reviews had been carried out in the last 12 months.
- We were told that Park Medical Centre has had a long standing history of providing care to drug users and championing the provision of these services in primary care. The practice had a relatively large amount of substance misuse patients and there were Drug and Alcohol workers attached to the practice three days per week, which allowed effective monitoring of these vulnerable patients. There were 58 on substitute medication that were being supported by these workers. Their role was to support these patients via holistic care plans that addressed areas such as drug use, criminality, housing and social functioning. We saw they would refer patients to other services such as Cognitive Behavioural Therapy (CBT). They worked in partnership with the lead GP who had the RCGP Certificate parts 1 and 2 in the management of drug misuse Patients were referred by the criminal justice system, the GPs or self-referral. Patients were reviewed on a regular rolling three month cycle.
- The practice was part of a local pilot that offered community based detox to appropriate clients within the borough and this is co-coordinated by the alcohol recovery worker.
- The practice had a register of patients experiencing poor mental health. These patients were invited to attend annual physical health checks and all 146 had been reviewed in the last 12 months. There was a mental health lead GP and a primary care mental health worker (PCMH) was based at the practice one day a week. Their role included supporting patients with mental illness transfer from secondary care back to primary care. GPs could also refer new patients to them. We saw there were monthly reviews of all patients being seen by the PCMH worker with the lead GP. Patients were also referred to other services such as IAPT (Improving Access to psychological therapies) for CBT and counselling. An IAPT therapist was based at the practice once a week. 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 presented. The practice based pharmacist also provided care for patients with mental health needs by carrying out medication reviews and also periodically checking that prescriptions had been picked up from the pharmacy and take appropriate action where they have not been.
- There was a GP lead for dementia and they carried out advanced care planning for patients with dementia and had achieved 100% of the latest QOF points which was above both CCG and national averages. We saw the practice had carried out an environmental dementia friendly audit and had scored 95% for 'the environment promotes calm safety and security for people with dementia in their care'. All staff at the practice had received training in understanding and identifying Dementia.
- The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. Accessible toilet facilities were available for all patients attending the practice. They had access to interpreters when needed.

Access to the service

The practice was open from 8.30am to 6.30pm Mondays to Fridays, but was closed for lunch between 12.30pm and 1.30pm. They provide extended hours on a Thursday to 7pm, which was particularly useful to patients with work commitments. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP, a nurse and the practice pharmacist. Pre-bookable appointments could be booked up to two weeks in advance; urgent appointments were available for people that needed them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

They also provided a telephone triage service. This had reduced the need for patients to have a face to face appointment with a GP.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 61% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 56% patients said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average 73%.
- 63% patients described their experience of making an appointment as good compared to the CCG average of 70% and national average of 73%.
- 58% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63% and national average of 65%.

The practice was aware of patients concerns about the phone system and opening hours. When we inspected they had recently installed a new phone system and patients we spoke with told us it had improved the ability to get through to the practice. Further, they had been actively trying to negotiate with NHS England for about three months to provide additional extended hours, however the local extended hours scheme by the CCG was not open and they have not been able to provide them a contract. They plan to provide a combination of early and late appointments as soon as they are allowed to.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. All verbal complaints were recorded on a spreadsheet.
- The practice managers handled all complaints in the practice. We saw that these were analysed on a quarterly basis and the outcome and actions were sent to all members of staff. 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 12 months and found these were dealt with in a timely way, in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we saw that where there was a delay to a diagnosis as the patient did not receive their results from the hospital the practice had written and apologised to the patient and had implemented a process of checking with patients two weeks after their appointments to ensure they had received them.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice vision and values was to provide the highest quality of care to their patients within a learning environment. All staff we spoke with knew and understood the vision and values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were monitored and updated annually.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.
- 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 had to read the key policies such as safeguarding, health and safety and infection control as part of their induction. All six policies and procedures we looked at had been reviewed annually and were up to date.
- 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 887 out of 900 in 2014 and 541 out of 559 in 2015 which was 6% above the CCG average and 2% above England average. We saw QOF data was regularly reviewed and discussed at the weekly clinical and monthly practice meetings. The practice also took part in a peer reviewing system with neighbouring GP practices in Hammersmith and Fulham.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements. There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records.

Leadership, openness and transparency

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice had weekly team meetings. We saw from minutes that these meetings were also used for training and updates.
- 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

Are services well-led?

Outstanding ☆

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

well together and that they were a highly functional team which listened and learnt, and were aware of their areas for improvement, such as the need to improve their phone system.

- We noted that team away days were held every year and staff told us these days were used both to assess business priorities and socialise with colleagues.
- Staff said they felt respected, valued and supported, particularly by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, last year's survey had identified concerns about the time it takes to check in when the reception is busy. As a result the practice had decided to install an electronic checking in system. Further, a visually impaired patient had provided visual awareness training to the practice.
- Some of the PPG carried at a number of activities to raise money for social services and local voluntary charities. We saw they had arranged a raffle for unwanted Christmas presents and had raised £800, which was used to purchase a swing for the local park.
- The practice manager had an 'open door' policy where they met with patients to discuss any concerns, feedback or resolve any complaints.
- There are high levels of staff satisfaction. The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to raise concerns. All staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice and the practice team was forward thinking. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. The practice took part in local pilot schemes to improve outcomes for patients in the area. For example, the practice had appointed a pharmacist who was responsible for the prescribing processes and carrying out reviews of LTC patients. We noted there were clear outcome measures in place to assess the impact and success of the post. Due to the success of the pilot the CCG agreed that five other local practices can implement similar posts and Park Medical Centre pharmacist was leading the recruitment for these practices. It was also agreed that they would also manage these pharmacists. The practice also trained community pharmacists and had sponsored one to complete their independent prescribing course last year.

The practice was also a training practice and had trained and mentored a wide range of health professionals such as GPs, the community matron and district nurses. All GP partners were qualified trainers. At the time of our inspection they employed three trainee GPs. The practice took part in joint tutorials with two other local practices to access better quality specialist training and the lead partner had provided six training sessions in the last six months. They had also provided training to the Health Education North West London (HENWL) GP retainer scheme training programme and a Doctors Update course abroad. We were also told that doctors from a local prison had completed placements at the surgery. The idea was to keep their skill set up to date and provided them with support and mentoring for their challenging role.

A systematic approach was taken in working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. All partners were involved in various external boards and organisations such as CCG, HENWL and Hammersmith and Fulham GP Federation. We saw that information from all these forums were fed back to practice staff at the weekly practice meetings.

Are services well-led?

Outstanding ☆

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

There is strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences. The practice carried out team learning at the weekly meetings. For example, we saw the substance worker had provided training on alcohol awareness, MIND had delivered training on the different forms of schizophrenia and the CCG dementia lead had provided dementia awareness training. The practice had also introduced bi- annual Schwartz roundswhich provided a structured forum where all staff got together to discuss the emotional and social aspects of working in healthcare.

The practice also took part in a pilot involving HENWL, the LMC and Communities into Training and Employment (CITE) to use general practice as a place for training administrative apprentices.

Further, in the last 5 years they have hosted 64 young people from local schools and colleges on work experience placements.