Belsize Priory Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive focused inspection at Belsize Priory Medical Practice on 4 December 2017. This inspection was carried out as part of our inspection programme. There was a new provider, Dr Nabila Muslem Abdulsahib Hanosh, who took over the running of the practice in 2016. This was the first, comprehensive inspection for the new provider.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The provider was aware of, and complied with, the requirements of the duty of candour.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided.
- Care and treatment was delivered according to evidence- based guidelines.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The leadership team were committed to service development and were working to improve the quality of the service.
- The practice proactively sought, and acted on, feedback from staff and patients.

However,

Summary of findings

- Patients found that there were long waiting times for appointments.
- The GP Patient survey suggests had not always involved patients in their care.

- The practice had good facilities; however the lift to the first floor remains out of use.
- Staff had relevant training for the role, but the practice had not always identified and monitored where staff may need additional training, such as in the requirements of the Mental Capacity Act (2005) or in fire safety.

The areas where the provider **should** make improvements are:

- Implement strategies to improve cervical screening uptake among women attending the practice.
- Staff should take action to involve patients in their care and consistently treat patients with kindness and respect.
- Continue to review patient feedback and take action to improve in areas where patients indicate that they are not satisfied with the service provided.
- Take action to satisfy themselves the premises and equipment used by the service are properly maintained.
- Review actions already taken to improve waiting times to assess the impact of these, and the sustainability of any reductions in waiting times.
- Review protocols for risk assessing staff that do not require a Disclosure and Barring Service (DBS) check to carry out their role.
- Assess staff training requirements in relation to fire safety and the requirements of the Mental Capacity Act (2005).

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

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
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

Belsize Priory Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. They were supported by a GP specialist adviser.

Background to Belsize Priory Medical Practice

The Belsize Priory Medical Practice is located in the London Borough of Camden at the following address: 208 Belsize Road, London NW6 4DX. The registered provider and Lead GP is Dr Nabila Hanosh. Further information about this practice can be found on the website: www.belsizepriorymedicalpractice.co.uk

The practice serves approximately 4,400 people living in the local area. People living in the area speak a range of different languages and express a range of cultural needs. The practice population has higher numbers of working-age people (aged 40+ years), and has higher levels of deprivation, compared to the national average.

The practice operates from a single site, which we visited as part of our inspection. It is situated on the first floor of a purpose-built health centre, which also houses a range of other health and social care services. There are six consulting rooms. The service can be accessed by a ramp leading to the first floor. There is also a disabled toilet available.

The practice is registered with the Care Quality Commission (CQC) to carry out the following regulated activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Treatment of disease, disorder or injury.

The practice is led by a female GP; there are also four other long-term GP locums (1 male GP and 3 female GPs). There a healthcare assistant and a range of non-clinical support, staff including a practice manager, supporting the GPs.

The practice offers appointments on the day and books appointments in advance. The practice has appointments from 9.00am to 6.30pm on Monday to Friday. The practice provides extended opening hours on Tuesdays between 6.30pm and 7.15pm and on Thursdays between 6.30pm and 7.00pm.

The practice hosts a range of additional clinics comprising: a Diabetic Specialist Nurse clinic once a month on a Tuesday; psychological support clinics on Thursdays and Fridays, a social connections clinic on Tuesdays, and an opiate drug misuse clinic every two weeks.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out (DBS
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.

Good

Are services safe?

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, the practice had experienced a brief power cut in November 2017. This had led the practice to instigate its business continuity plan to ensure minimal disruption to the service. The practice had identified risks, for example, in relation to the storage of vaccines in fridges, and take appropriate steps to investigate and mitigate these risks. The practice subsequently reviewed the incident with staff and took action to update their continuity plan in light of what had been learnt during event.
- However, overall we found that reporting of significant events was relatively low compared to the practice size; with three events recorded in 2016 and two events in 2017.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice good for providing effective services overall and across all population groups except for the working-age population group which we rated requires improvement.

The practice was rated as requires improvement for providing effective services to the working-age population group because:

- Uptake for cervical screening to prevent cancer was low among women attending the practice.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice monitored prescribing rates and reviewed data provided by the Camden Clinical Commissioning Group (CCG) to show how the practice had performed in relation to other practices in this area. We found that the practice prescribing was in line with recommended performance.
- For example, the average daily quantity of Hypnotics (sleep-inducing medicines for the use in managing conditions like insomnia) prescribed per Specific Therapeutic group of 0.78 was in line with the CCG average of 0.88 and the national average of 0.90. The practice showed us data confirming they were a middle-ranked prescriber (12th out of 34 practices) for this type of medicine in the CCG.
- Similarly, the practice showed us data confirming that their prescribing for antibiotic items (Cephalosporins or Quinolones) was comparable to the CCG with 143 items prescribed per 100 patients; they ranked 16 out of 34 practices in the area.
- The practice was also a relatively low prescriber of wider antibacterial items compared to the national average, but this was in line with prescribing practices within the CCG area. (The average number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit was 0.67 for the practice, 0.58 for the CCG and 0.98 for England as a whole).
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice held multi-disciplinary team (MDT) meetings with other providers, depending on the level of risk and care needs identified by the practice for each individual. For example, 'mild frail' patients were reviewed within the practice MDT, which was attended by complex care nurses, care navigators and physiotherapists. The practice could also escalate concerns for severely frail patients to an MDT Hub (borough-wide) to develop a comprehensive care plan with a range of other providers.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice had used the information collected for the Quality and Outcomes Framework (QOF) to monitor

Good

Are services effective?

(for example, treatment is effective)

outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The practice had taken action to improve their performance in the areas where they had identified that they did not perform as well as other practices.For example, performance for diabetes related indicators had been lower than the national average with QOF data for 2016/17 showing that 63% of patients having an acceptable blood sugar reading compared to an England average of 79%. The practice had subsequently targeted this patient group for additional education and review meetings. The practice showed us the data for this patient group for the period April to December 2017 indicating that 80% of patients now had acceptable blood sugar readings.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were 85% for two-year olds and 83% for five-year olds for the year to date. This showed that the practice was in line to meet the target percentage of 90% or above by the end of the financial year (2017/18).
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- Uptake for cervical screening to prevent cancer was low among women attending the practice.
- The practice's uptake for cervical screening was 63%. This was below the 80% coverage target for the national screening programme. We discussed this with the lead GP. They were aware of the issue. They commented that the practice had been without a practice nurse for over a year and therefore the GPs were fully responsible for delivering the cervical screening programme. They had found that many women in the area were reluctant to attend for this type of screening and were considering options for further outreach and education.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End-of-life care was delivered in a coordinated way which took into account the needs of those 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.

People experiencing poor mental health (including people with dementia):

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, there were a high percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 92%; CCG 90%; national 91%).
- The practice had a 'team around the practice' service providing psychological support to patients who needed it during a weekly clinic.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The most recent published Quality Outcome Framework (QOF) results were 93% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%. The overall exception reporting rate was 4% compared with a national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice was actively involved in quality improvement activity.
- Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice provided staff with
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up-to-date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- However, we noted some gaps in the training programme for staff. For example, we did not see evidence that all of the GPs working at the practice had completed infection control training within the past year. The lead GP had completed Mental Capacity Act (MCA; 2005) training within the past month, but we saw no evidence related to the training of the locum GPs in this topic. We also saw that the majority of staff had completed some fire safety training, but the locum GPs had not done so. The practice manager confirmed with us, after the inspection, that the locum GPs had been asked to complete fire safety training by the end of March 2018. The lead GP had also booked onto an infection control training course in February 2018.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers, as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.
- The health care assistant was a trained smoking cessation adviser. The practice showed us that the work of the assistant had been recognised in an email from the CCG's 'Smokefreelife' team discussing the higher number of quit attempts from patients at the practice.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 43 patient Care Quality Commission comment cards we received were positive about the service experienced in terms of the caring attitude of staff.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 385 surveys were sent out and 103 were returned. This represented about 2% of the practice population. The practice was average for its satisfaction scores on consultations with GPs. For example:

- 81% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 90% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 81% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average -87 %.
- 76% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.

However

- 71% of patients who responded said the GP gave them enough time; CCG - 86%; national average - 86%.
- 73% of patients who responded said the nurse was good at listening to them; (CCG) - 86%; national average - 91%.
- 73% of patients who responded said the nurse gave them enough time; CCG - 88%; national average - 92%.
- 84% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 96%; national average - 97%.
- 74% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 87%; national average - 91%.

We discussed these results with the lead GP. They were aware of the results from the national survey and had a written action plan to address the highest priority concerns. These related to: reducing waiting times for patients, increasing the number of patients who reported they could see their preferred GP and overall increasing the numbers of patients who would recommend the practice to others. The results in relation to nurses were ambiguous as there had not been a practice nurse in place for over a year. There was a health care assistant working at the practice. We saw evidence that a review of this staff member's interactions with patients had taken place due to patient complaints and was documented in the staff file. The practice manager monitored patient feedback and complaints to identify if any further training was required for staff.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation 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. Patients were also told about multi-lingual staff that might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.

Good

Are services caring?

- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. This was done through collating information during registration and in an ad hoc way during patient consultations. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 53 patients as carers (1% of the practice list).

- The practice had recently invited a local carer's organisation to visit the practice. They had invited carers to attend an event which explored options for extra support. A second day with this organisation had been booked so that staff could be provided with training in how to identify and support carers.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them 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.

Results from the national GP patient survey showed patients' responses to questions about their involvement in planning and making decisions about their care and treatment. Results were either in line with, or lower than local and national averages:

- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 80%; national average - 82%.
- 74% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 86% and the national average of 86%.

As noted above, the lead GP had selected some key target areas for improvement in relation to the results from this survey. They also commented that there had been a rapid turnover of staff over the past 18 months, including the loss of the practice nurse and recruitment of new, long-term locums. They anticipated that results in this area would now improve following a period of staff stability.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice was aware that a larger than average proportion of their patients were of working age. Therefore, they offered extended opening hours on Tuesdays and Thursdays as well as online services such as repeat prescription requests, advanced booking of appointments, and telephone consultations for common ailments.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

However, we also found

- The facilities and premises were not appropriate for the services delivered. For example, the consultation rooms were on the first floor of the building. There was a lift which had been out of order for over two months. Patients with impaired mobility, or wheelchair users, could still access the building via a ramp, but may have required extra support to do so. Staff had not had formal training in moving and handling to support patients, but did offer to assist patients, where necessary.
- The lead GP told us that they had consistently reported the issue with lift to the building management company, but that this had failed to resolve the issue.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local multi-disciplinary team and hub to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, through extended opening hours on two days of the week.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice worked closely with a local women's refuge to support women affected by domestic violence to access physical and mental healthcare.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice pro-actively screened patients for dementia prior to referral to a local memory clinic and ensured that annual physical and mental health checks were carried out for these patients.
- The practice maintained a register of patients with mental health diagnoses to ensure timely checks and follow ups were carried out.
- The practice hosted two psychological support clinics at the practice each week to promote access to specialist mental health support services.

Timely access to the service

Patients were able to access care and treatment from the practice, but this was not always within an acceptable timescale for their needs.

- Patients with the most urgent needs had their care and treatment prioritised through the use of emergency appointment slots which were held each day.

The results from the July 2017 annual national GP patient survey also showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- 72% of patients who responded said they could get through easily to the practice by phone; CCG – 75%; national average - 71%.
- 87% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 83%; national average - 84%.
- 71% of patients who responded described their experience of making an appointment as good; CCG - 71%; national average - 73%.

However, there remained some areas for improvement.

- 66% of patients who responded said their last appointment was convenient; CCG - 78%; national average - 81%.
- 30% of patients who responded said they don't normally have to wait too long to be seen; CCG - 56%; national average - 58%.

This was supported by observations on the day of inspection and completed comment cards:

- The reception staff told us that the next pre-bookable appointment was in 19 days' time.
- 10 out of the 43 comments cards (23%) we received contained negative information about long waiting times in reception and difficulty with access to appointments.
- Patients that we spoke with commented that they had experienced waiting times of over an hour, but also reported an improving picture with waiting times in recent months coming down overall.

The GP lead had an action plan to improve performance. They had instigated:

- a review of the telephone reception triage procedure for offering appointments
- increased the availability of 'double' appointment slots for those with complex needs
- refreshed the locum induction pack to include information who to access for support of complex patients within the practice
- given staff instruction on limiting non-urgent interruptions during consultation clinics.

The goal was to decrease the amount of waiting time in the reception area and overall improve the flow of patients through the practice by providing appropriately timed appointments.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Fourteen complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, staff were attended meetings with the lead GP and practice manager to review their communication skills in the event of complaints related to staff attitude.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

The practice monitored progress against delivery of the strategy. There was a barrier to implementing the current strategy as the lease on the current building hosting the practice was due to expire in December 2018. The lead GP had been liaising closely with the CCG regarding the re-housing of the practice; however concerns remained at the time of the inspection that building work had not yet commenced, and plans were not sufficiently advanced, for housing the practice in 2019.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. For example, we reviewed one incident that had been investigated by the practice in relation to the incorrect issuing of a prescription medicine. We found that the practice acted promptly to address the issue and prevent harm to the patient, had apologised to the patient, and offered to hold a face-to-face meeting with the patient and their relatives to review the incident.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support governance and management. For example:

Are services well-led?

Good

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

- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

There were some areas where governance arrangements needed a review:

- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There was one area, related to risk assessments for staff who did not need a Disclosure and Barring Service (DBS) check, which required improvement.
- There were structures, processes and systems to support good governance and management and these were clearly set out and understood.
- However, we noted that the practice had not monitored all aspects of staff training, for example, in relation to the completion of Mental Capacity Act (2005) training, and formal fire-safety training.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice had an active patient participation group which met approximately four times a year. Minutes from these meetings showed that patients were able to raise their concerns as well as explore areas for improvement within the practice.
- The service was transparent, collaborative and open with stakeholders about performance. For example, the practice was part of a group of federated practice who shared monthly feedback on their performance in relation to the care of patients with long-term conditions.

Are services well-led?

Good

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

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example, the practice had volunteered to take part in a new programme to improve the management of children and young people with asthma.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.