The Abbey Medical Centre

Quality Report

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Date of inspection visit: 19 January 2017
Date of publication: 28/04/2017

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Abbey Medical Centre on 19 January 2017. Overall the practice is rated as outstanding.

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

- Staff used an effective system report and investigate significant events and the working culture encouraged openness and honesty to highlight areas for improvement.
- Risks to patients were assessed and well managed, including through medicines management and safeguarding processes.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of extensive and consistent multidisciplinary working to meet the complex needs of patients, including vulnerable young people and those who received palliative care.
- A comprehensive programme of audits was in place and staff used this to assess quality of care and establish standards against national best practice guidance. The audit programme had demonstrably led to improvements in practice.
- Patients provided positive feedback about the caring nature of staff and said they took the time to listen to their concerns. We saw staff treated people with compassion, dignity and respect and involved them in care planning and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- GPs had developed a significant range of multidisciplinary services to meet the complex needs of the location population that included young people with brain injuries, patients with needs relating to drug addiction and those under child protection orders. An on-call, responsive and individualised service was provided that included patients who lived in protective or sheltered accommodation.
- Care for patients with safeguarding needs extended beyond the practice's immediate responsibility. This included proactive working with schools, key workers, social workers and the police. Children at risk, refugees and homeless patients were offered an on-demand service by a team of staff who adapted the electronic patient records system to improve tracking and who undertook regular training with specialist teams to be able to deliver such services safely.

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 although there was room for improvement in the consistency of this.
- Staff worked in an environment that encouraged self-reflection and had a low threshold for identifying risk. This meant staff reported near-misses or incidents that had been avoided so that the team could learn from each other's experiences and implement strategies to reduce risk.
- 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 and staff could evidence how they adhered to the principles of the duty of candour.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- A named GP was the lead for child protection and demonstrated an extensive programme and track record of support and multi-agency working.
- All staff had recent Disclosure and Barring Service clearance.
- Risks to patients were assessed and well managed including in relation to medicines management and action taken as a result of national safety alerts.
- The practice had an up to date health and safety policy and emergency policies and equipment were regularly tested.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were similar to or better than the national average. Exception reporting rates were comparable to, or better than, the national average in 19 clinical domains and significantly better than the national average in two clinical domains.

Summary of findings

- Staff assessed needs and delivered care in line with current evidence based guidance and there was a structured system in place to ensure updates were tracked and applied to practice policies. All relevant staff had access to this system and could demonstrate how it impacted their work.
- Clinical audits demonstrated a consistent drive to establish and improve quality of care and patient outcomes. Audits were focused on the needs of the local population and trainee doctors were actively involved in them as part of their professional development.
- Staff had the skills, knowledge and experience to deliver effective care and treatment because they had access to on-going clinical training.
- There was consistent evidence of effective appraisals and personal development plans and structured support and mentorship for new and trainee staff.
- There was significant focus on education provision, including weekly protected teaching time, peer consultations and structured bi-monthly tutorials for trainee doctors.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs, including those with mental health needs and substance addiction. This followed a successful mental health pilot scheme that resulted in on-site mental health support being provided on a regular basis from a community psychiatrist, psychologist and mental health nurse.
- The practice worked with geriatricians, nursing and community support teams to provide care to patients who lived in nursing and residential homes. A GP frailty lead was in post and supported led health assessments, home visits and coordinated care.
- Multidisciplinary meetings took place monthly including for frailty, end of life and complex care. There was an established and extensive provision for the care of patients with mental health needs, including those with schizophrenia, personality disorders and needs relating to self-harm, drug use and high-risk sexual behaviour.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients reported they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- The practice facilitated access to services that could provide emotional support and guidance to patients from diverse cultural backgrounds and ethnic minority groups.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There was evidence staff routinely included patients in their own care and adhered to best practice principles in allowing patients to make their own decisions, including unwise decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the Clinical Commissioning Group and other local organisations to secure improvements to services where these were identified. This included in the reduction of prescribing antihypnotic drugs through the provision of more structured multidisciplinary mental health support.
- Patients said they found it easy to make an urgent appointment and there was continuity of care, with urgent appointments available the same day and a daily duty doctor triage service.
- 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 evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice provided a number of services for patients including practice nurse home medicine reviews for housebound patients, liaison services with community drug rehabilitation teams and home visits for young people with complex learning disabilities.
- The practice regularly reviewed how people accessed services and provided a responsive service as a result. This included adapting online software to better support patients who used smartphones and enabling patients to communicate with GPs by e-mail.
- GPs undertook proactive case reviews where they thought their response to a patient's medical concern could have been improved. This was a peer-review process that took place with the patient's consent and enabled GPs to identify strategies to provide the best level of care for specific conditions.

Summary of findings

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had up to date policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework that supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient representative group was proactive and produced an annual action plan, which we saw was used to improve patient experience.
- The practice demonstrated a commitment to the health and wellbeing of its staff and had supported them professionally and personally during a period of significant and unpredictable change.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for providing services to older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- A GP frailty lead was in post and provided targeted care and reviews for patients with a well-coordinated multidisciplinary team.
- A planned care lead was in post who offered extended appointments for patients and worked with a care navigator to support patients over the age of 60.
- Staff worked with community rehabilitation therapists, dietetics, phlebotomy and community nursing teams to provided individualised, coordinated care.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice invited all patients over 75 years old to attend an annual health assessment that included a blood test, medicine review and advice regarding diet and lifestyle.
- Staff offered dementia screening and referrals to a memory clinic as well as assessments using a frailty pathway. This helped to ensure patients received care that met their changing needs.
- The practice provided a dedicated service to 140 patients in nearby residential and nursing homes. Each patient had a named GP and the homes had direct mobile telephone access to them. A named receptionist provided single point of contact access to the practice and appointments.

People with long term conditions

Good

The practice is rated as good for providing services to people with long-term conditions.

- Individual GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- A GP contacted patients who attended hospital unexpectedly to support them in managing their condition.
- Performance for diabetes related indicators was better than the national average. For example the percentage of patients with diabetes in whom the last blood pressure reading (measured in

the preceding 12 months) was 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 87% compared to the CCG average of 76% and the national averages of 78%. The percentage of patients in the same period in whom the last measured total cholesterol was 5mmol/l or less was 87% compared with the CCG average of 82% and national average of 80%. Longer appointments and home visits were available when needed.

- A GP lead was in post for patients with complex care and worked with a wide multidisciplinary team to provide individualised care, including out of hours through a local federation.
- A range of services were offered on-site, including phlebotomy, spirometry and electrocardiograms.

Families, children and young people

Good

The practice is rated as good for providing services to families, children and young people.

- There were systems in place to identify and support children living in disadvantaged circumstances. This included those who were at risk such as children and young people who had a high number of emergency hospital attendances.
- Immunisation rates were relatively high for all standard childhood immunisations and comparable to local and national averages.
- The practice's uptake for the cervical screening programme was 77%, which was comparable to the CCG average of 72% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies including a dedicated children's waiting area.
- The practice provided specialised care and support for children with needs relating to autism.
- The practice had established relationships with local schools to provide care, including school visits for health checks, to bridge a gap in care due to a shortage of local school nurses.
- A GP was the dedicated child protection lead and worked closely with health visitors to provide care and support. The GP also worked with alcohol and drug counsellors and mental health specialists to support young people with complex needs.
- The practice offered new born baby checks, antenatal and postnatal care and sexual health screening.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing services to 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 range of health promotion and screening that reflected the needs of this age group, including in relation to alcohol consumption and recreational drug use.
- The practice offered extended hours to support those patients that could not attend appointments during standard working hours and facilitated e-mail communication between GPs and patients.
- The patient participation group was actively promoting recruitment to this age group to improve their representation at practice development meetings.
- GPs offered telephone consultants and email communication and facilitated patient access to an online psychology service.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for providing services to people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, those over 75 years of age living alone, those with a learning disability and patients with refugee status.
- 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 informed vulnerable patients about how to access various support groups and voluntary organisations, including those providing services to specific cultural groups.
- 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 demonstrated a proactive approach to engaging other agencies for urgent support.
- Patients who were considered vulnerable were given same day priority appointments.

Summary of findings

- The practice maintained registers of patients who were known to suffer domestic violence or had experienced female genital mutilation. These patients were offered access to urgent appointments.
- GPs worked with social workers to provide dedicated support to patients living in emergency or sheltered housing as well as people with refugee status and those who were homeless.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing services to people experiencing poor mental health (including people with dementia).

- 80% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average of 84%. The practice had exception reported 4% compared to the national average of 7%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had a designated dementia support lead who was responsible for overseeing the treatment of all diagnosed patients.
- The practice carried out advance care planning for patients with dementia.
- 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.
- The practice had participated in a pilot scheme to improve access for patients to mental health services in the practice. This had resulted in regular access to drug and alcohol counsellors, a community psychiatrist, mental health nurses and a psychologist.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 and related to feedback collected between July to September 2015 and January to March 2016. The results showed the practice was performing in line with local and national averages. Three hundred and fifty survey forms were distributed and 95 were returned. This represented 1% of the practice's patient list.

- 58% of patients found it easy to get through to the practice by phone compared to the Clinical Commissioning Group (CCG) average of 75% and the national average of 73%.
- 70% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG and national averages of 76%.
- 77% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 85% of patients said the last GP they saw was good at giving them enough time compared to the CCG average of 85% and the national average of 87%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards which were all positive about the standard of care received. The general themes were that staff were friendly and caring and offered a personalised service. Patients said that receptionists were particularly welcoming and took the time to listen and understand patient's concerns. Ten patients noted they felt involved in their care planning and several patients commented they felt their appointments were interactive.

Areas for improvement

Outstanding practice

- GPs had developed a significant range of multidisciplinary services to meet the complex needs of the location population that included young people with brain injuries, patients with needs relating to drug addiction and those under child protection orders. An on-call, responsive and individualised service was provided that included patients who lived in protective or sheltered accommodation.
- Care for patients with safeguarding needs extended beyond the practice's immediate responsibility. This included proactive working with schools, key workers, social workers and the police. Children at risk, refugees and homeless patients were offered an on-demand service by a team of staff who adapted the electronic patient records system to improve tracking and who undertook regular training with specialist teams to be able to deliver such services safely.

The Abbey Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP specialist adviser.

Background to The Abbey Medical Centre

The Abbey Medical Centre is a purpose-built GP practice set over two floors. The building has level access from the street and lift access that enables step-free access to all areas. There are two waiting rooms and a dedicated children's area. This is a teaching practice and patients may be seen by trainee GPs. The practice is based at 85 Abbey Road, London NW8 0AG.

The Abbey Medical Centre is one of a number of GP practices commissioned by Camden Clinical Commissioning Group (CCG). It has a practice list of 10,402 registered patients. The practice is in the fourth most deprived decile out of 10 on the national deprivation scale. The practice has a higher percentage of unemployed patients (9%) compared to the local average of 7% and national average of 5%.

The practice staff includes three GP partners, five salaried GPs and four trainee doctors (registrars). There are eight female GPs and four male GPs. There is a full time healthcare assistant and a part time locum practice nurse. At the time of our inspection the vacant practice manager post had been filled by a new business manager, who was due to start imminently. A team of receptionists, secretaries and administrators provided non-clinical services.

The practice is open and offers appointments during the following hours:

Monday - 7am to 6.30pm

Tuesday - 8am to 8pm

Wednesday - 8am to 1pm

Thursday - 8am to 6.30pm

Friday – 8am to 6.30pm

A local GP federation provides services seven days a week from 6.30am to 8.30pm Monday to Friday and from 8am to 8pm at weekends. Outside of these hours cover is provided by the NHS 111 service.

We had not previously carried out an inspection at this practice.

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 practice and asked other organisations to share what they knew. We carried out an announced visit on 19 January 2017.

During our visit we:

- Spoke with a range of staff including GPs, members of the patient participation group, the deputy practice manager and the incoming business manager.
- Observed how patients were cared for.
- Reviewed an anonymised sample of the personal care and treatment records of patients.
- Reviewed clinical audits and the investigations of significant events and complaints.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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 and learning

There was an effective system in place for reporting and recording significant events.

- Staff submitted incident reports using an electronic system and the GP partner's maintained oversight of this. In addition staff could escalate incidents directly to the partners for immediate support and action. The incident recording form supported the recording of notifiable incidents under 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.
- The safety culture of the practice meant there was a low threshold for incident reporting. Staff were proactive in submitting incident reports even when there was no harm or other negative outcome, such as in the case of near misses. There was a reporting template for near misses that staff used to review such situations and identify strategies to reduce future risk.
- There had been 12 significant events in the 12 months prior to our inspection. We looked at the investigation and outcomes of each and saw that action plans and learning were identified, with changes implemented. For example, when a parent brought an unconscious child into the practice, staff reviewed the incident and identified improvements to their emergency response procedure. This included emergency grab bags and time sheets so staff could record important information while awaiting paramedics.
- As a result of an incident that involved a flu vaccine being administered to a patient with memory problems, staff improved the safety procedure to ensure GPs had time to check patient history before administering a vaccine.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes.

We reviewed safety records, incident reports, patient safety alerts and minutes of the monthly team meetings where these were discussed. We saw evidence that action was taken as a result of national patient safety alerts, including an immediate search for patients who received the medicine concerned and an appointment scheduled with them to discuss alternative treatments.

Overview of safety systems and processes

The practice had clearly defined and embedded safeguarding systems, processes and practices in place to keep patients safe:

- There were partner GP leads in place for child safeguarding and adult safeguarding. One GP was the designated lead for child protection. They had established a child protection register, dealt with all child protection queries and met with health visitors every three months to review children under five years old considered to be at risk.
- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and each individual could demonstrate how they accessed them. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. For example, if a known vulnerable child did not attend a booked appointment, staff escalated this to the child protection lead.
- The electronic patient records system had been adapted so that if one patient was known to be vulnerable, this information would be flagged on the record of any family member who lived in the same home. This helped staff to identify when others might be vulnerable or at risk. GPs attended safeguarding meetings and provided collaborative reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to adult and child safeguarding level three and non-clinical staff were trained to level two.
- A notice in the waiting room advised patients that chaperones were available if required. All members of staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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). Staff documented in patients' notes if a chaperone had been offered and when a chaperone was used.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A GP was the infection control lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe. This included in obtaining, prescribing, recording, handling, storing, security and disposal. Processes were in place for handling repeat prescriptions, which included the review of high risk medicines. The practice carried out regular medicines audits with the support of the local CCG pharmacy teams to ensure prescribing was in line with best practice guidelines.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (A PGD is a written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition.)
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

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. There was a health and safety policy in place and all staff were aware of their responsibilities. 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. 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, infection control and Legionella (Legionella is a term for a particular bacterium that can contaminate water systems in buildings).
- Two trained fire marshals were in post and there was always a designated evacuation lead on duty. Learning had taken place from the last fire drill, which included an instruction to staff to act immediately on hearing the fire alarm and not wait for further instructions.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Learning from a significant event had resulted in an improved GP planning tool that ensured GPs with capacity for urgent and walk-in appointments were scheduled to be on site following public holidays.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to an emergency. Each telephone had a panic alarm fitted that would sound throughout the practice.
- All staff received annual basic life support training and emergency medicines were available.
- An automatic defibrillator was available and every treatment room had an anaphylaxis kit. Oxygen with adult and children's masks was available on both floors and emergency equipment was clearly signed. We saw evidence that equipment was regularly checked to ensure all equipment was available, in date and fit for purpose. A first aid kit and accident book were available and a biohazard spill kit was stored at reception.
- 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 stored securely.
- The practice had an up to date 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 external service contractors. Every member of staff was given a copy of the plan and this was also accessible off site in case the building became inaccessible. During a recent

Good

Are services safe?

emergency situation in which the lower level of the practice had flooded, the team demonstrated that emergency contingency plans worked well in practice to minimise disruption to the service and to keep people in the building safe.

Outstanding ☆

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. National patient safety alerts were received by the lead GP partner who cascaded them to the relevant team members. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Updates to national guidance, policies and alerts were documented on the electronic system so the partners could ensure care and treatment reflected latest recommendations.
- The practice monitored that guidelines were followed through risk assessments, audits and random sample checks of patient records. All alerts were discussed at team meetings and trainee GPs had the opportunity to discuss these and how they applied to patients during regular supervisions.
- All patient referrals were submitted through a centralised system operated by the CCG. This meant the quality of referrals was monitored and standardised and ensured patients had the most appropriate access to specialist care.

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 99% of the total number of points available. Overall exception reporting was 3%, which was lower than the CCG average of 4% and the national average of 6%. (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.)

Exception reporting was significantly lower than the CCG and national averages in the osteoporosis and primary prevention of cardiovascular disease clinical domains. For example, exception reporting for osteoporosis was 0% compared to the CCG average of 18% and the national average of 15%. Exception reporting for the primary prevention of cardiovascular disease was 0% compared with the CCG average of 36% and the national average of 31%. Performance in all other clinical domains was comparable to CCG and national practices.

This practice was not an outlier for any QOF or other national clinical targets. Data from 2015/ 2016 showed:

- Performance for diabetes related indicators was better than the national average. For example the percentage of patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2015 to 31/ 03/2016) was 87% compared to the CCG average of 76% and the national averages of 78%. The percentage of patients in the same period in whom the last measured total cholesterol was 5mmol/l or less was 87% compared with the CCG average of 82% and national average of 80%. Longer appointments and home visits were available when needed.
- Performance for mental health related indicators was better than or similar to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/ 03/2016) was 92% compared to the CCG and national averages of 90%. The practice exception reported fewer patients (2%) than the CCG average (5%) and national average (13%).

The partners, practice nurse and healthcare assistant held regular QOF meetings to review the current practice performance, identify areas for improvement and develop an action plan for continued improvement. For example, a lead for chronic obstructive pulmonary disease was in post and worked with patients to ensure their treatment and reviews were timely and in line with national guidance.

There was evidence of quality improvement including from a clinical audit programme, which all staff were encouraged to engage with:

- There had been 14 clinical audits undertaken in the 12 months prior to our inspection, all of which were completed audits where improvements were implemented and monitored.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice participated in local audits and benchmarking (including prescribing) to compare trends against local and national practices, accreditation and peer review.
- Audits were based on the needs and health trends of the local population, including to assess and benchmark the standard of care given in clinical areas such as frailty, end of life, epilepsy and patients prescribed analgesia.
- GPs provided services to patients who lived in residential homes and conducted audits with these groups to identify opportunities to improve care. For example, a GP who provided care to patients in a nursing home led an audit of patients who used sip feeds and supplements. Aa sip feed is a modified cup used by people with reduced grip or coordination in their hands. This included a check that each patient had a recent documented weight and had been prescribed a sip feed within the local formulary. Where a sip feed was used outside of this criteria, the GP reviewed if it was appropriate and in the patient's best interests. This audit also checked if patients had undergone a dietician review and was repeated at six months and nine months to ensure sip feeds were appropriate. Overall this audit included 25 patients and ensured their feeding regime was the most appropriate for them.
- An audit of patients who were prescribed medicine for diabetes found 11% of 337 individuals had low levels of vitamin B12. All of these patients were contacted and treated with B12 injections.
- An audit of patients who were prescribed steroids found only 18% had received a fracture risk assessment for osteoporosis, which is associated with long-term steroid use. As a result the practice implemented a new fracture risk assessment template that followed NICE guidance and recalled each patient to have this assessment completed. A re-audit identified all patients, except three individuals who refused, had undergone a risk assessment and appropriate action had been taken after the results.
- An audit of the treatment and care pathways used for patients with non-alcoholic fatty liver identified areas for improvement in the referral of patients and how they could be supported in the practice.
- Following an audit of the coding used in the electronic records system to identify children on the child protection register, the practice policy was changed to ensure only the child protection lead GP completed coding. This meant code entry was standardised and the practice could more easily identify and track individuals at risk.
- The practice had developed and implemented a follow-up template for patient blood results and this was audited monthly to ensure every blood result was followed up.
- The practice participated in the National Diabetes Audit and in 2015/16 achieved 56% of all treatment targets, which was the best result in the local borough.
- To improve the quality and consistency of referrals, the practice used a local referral management service with a failsafe system for checking referrals and issuing receipts. To date the practice had a track record of no missed or delayed referrals. This process was used as a quality checking system because when referrals were sent back with advice or guidance it meant GPs could identify more appropriate pathways, such as intermediate care. This also allowed the practice to benchmark themselves against others by the number of referrals returned with educational advice.
- The practice produced a monthly report of patient follow-ups and proactively contacted those who had not made an appointment. The electronic records system flagged pending follow-ups to GPs during appointments so that they could discuss this opportunistically with the patient.

The education lead GP had conducted a review of all patient referrals and worked with colleagues to complete peer reviews of each referral to identify good practice and areas for improvement. This included a review of the management of each patient's condition and the care pathway used to refer them.

The practice monitored hospital emergency attendances to assess the effectiveness of the overall care and education provided to patients as well as to benchmark performance against practices in the local area. The latest available data related to the period July 2016 to September 2016 and demonstrated the practice performed better than local averages. For example, a lower number of practice patients attended the emergency department with non-serious conditions (47% of attendances) compared with the local average of 51%. In addition, where a patient was admitted in an emergency, 44% experienced a stay of less than 48 hours. This was better than the local average of 49%.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

All patients who did not attend a booked appointment were contacted by a member of staff to reschedule or update their health record.

Effective staffing

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

- The practice provided health and safety guidance and training for all staff members that included first aid, waste handling, fire procedures and dealing with violent and aggressive behaviour.
- The practice had an induction programme for all newly appointed staff. The programme had been tailored to the various roles within the practice such as administration staff and locum GPs. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The locum induction pack was electronic and included access to the CCG intranet, guides to the electronic patient records system and information on making referrals through the centralised system.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions including asthma and diabetes.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training that included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, discussion at practice meetings and engagement with peers at neighbouring practices.
- Trainee doctors (registrars) had a mentor and undertook shifts with the duty GP to build their experience and skills in triage and handling urgent cases. The duty GP supervised the trainee doctor and provided structured peer support and feedback.
- Staff had access to ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. There was a consistent focus on education and professional development. One GP was the programme director for GP training at an acute trust and ran a self-directed learning group for GPs. This helped to support and embed a professional network for education in the practice.
- An educational lead GP provided a series of weekly meetings focused on topics to help support colleagues and drive improvement in practice. Most recently topics had included complex care, palliative care, frail elderly patients with multiple needs and multidisciplinary meetings aimed at establishing best practice with social workers and cancer nurses.
- The educational lead provided joint tutorials with trainee GPs every two months to consolidate learning and share their experiences, including through case reviews and peer feedback.
- The focus on education and development was embedded in the practice. Each GP held an educational talk for their peers on a complex case or point of learning and received feedback on this afterwards. In addition, each GP undertook a monthly peer consultation. This meant another GP observed a patient consultation and provided feedback afterwards. GPs we spoke with were positive about this process and told us it helped to improve practice as well as reduce GPs working in isolation.
- Reception and administrative staff were part of a community education provider network that enabled them to take part in training alongside GPs and the healthcare assistant to learn more about medical terminology and improve team working. This took place during weekly protected teaching time.
- All staff had received an appraisal within the last 12 months and the staff we spoke with said they felt appraisals were an effective way to identify their progress and support development needs. Appraisals were completed consistently and it was evident that they were used as motivational and development tools.
- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. We saw evidence that the practice responded to

correspondence such as test results on the same day and had an effective system to ensure the information was cascaded to the correct staff and recorded appropriately.

- The practice worked with the GP collaborative Camden Clinical Assessment Service that provided a referral assessment service to ensure each referral was appropriate and involved the best service option for the patient. This ensured patients had access to specialist care that was appropriate and reduced the need for referral to multiple services.
- The practice had a system in place to ensure two-week wait cancer referrals were received by the relevant service.
- A lead GP for hospital emergency department attendances was in post and this individual reviewed each patient attendance to assess appropriateness and whether a follow-up was required. A GP reviewed all unplanned hospital admissions daily and provided follow-ups as required.
- The practice had taken part in a 'team around the practice' (TAP) pilot scheme to improve access to mental health services. As a result of the pilot the practice hosted regular on-site specialist clinics by an alcohol support worker, a domestic violence worker a psychologist, community psychiatrist and a mental health nurse. GPs demonstrated proactive multidisciplinary care for patients with complex mental health needs. This included joint sessions with a drug counsellor for a patient with an addiction and weekly reviews for patients with personality disorders and schizophrenia. Staff had also coordinated care with key workers to support patients with mental health needs who had attempted suicide, self-harmed and/or been under police supervision.
- A lead GP for learning disabilities was in place and provided individualised care to young people who lived in supported housing. This included annual blood tests, electrocardiograms and a medicine weaning programme to reduce antipsychotic prescriptions. Each patient had a care plan book that the GP updated at each consultation so home staff and key workers could keep up to date.

Staff worked with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Integrated care management meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Staff worked with hospice nurses, social workers and district nurses to provide a coordinated care plan for patients who received palliative care. Staff attended multidisciplinary meetings and monitored end of life care to help meet each patient's final wishes, including preferred place of death.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance including the Gillick competencies and Fraser guidelines. We also saw evidence staff encouraged young people to talk to their parents or relatives about treatment to ensure they had support.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- GPs documented patient consent to use the out of hours federation service in advance. This meant if patients ever needed to use this service, the federation GPs were able to access electronic patient records and medical history.
- Patients who receive cryotherapy signed a consent form at the first treatment and staff documented verbal consent at subsequent appointments. We saw examples of this in practice.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support:

- Patients were signposted to relevant services to meet their needs, such as to a smoking cessation advisor. Staff also provided signposting and referral for those at

risk of developing a long-term condition and those requiring advice on their diet, drugs and alcohol cessation, patients over 75 years of age, and patients with no fixed abode.

- The practice flagged the computer records of patients who required additional support when attending the practice. This alerted staff to the specific individual needs of these patients when they presented at the reception counter.
- Staff provided sexual health advice to young people, including for family planning and contraception and for those with needs relating to high-risk sexual behaviour and drug use.
- Following the death of a registered patient over of the age of 75 who had never requested an appointment, the practice contacted every patient in this age group and scheduled them for a health check. This practice became an annual process to help monitor the health of older people.
- The practice operated its own online health blog, on which GPs published articles. This was available to patients and their relatives and was used to discuss current health concerns, give GP-led advice and to stimulate health promotion discussion. For example, a recent blog entry included an interview between a GP and their patient comparing the health systems of different countries. Another entry was about insomnia and provided guidance to readers on the condition. Access to the blog was monitored to determine it's reach and in the six months to January 2017 the site averaged 2500 visits per month.
- A wide range of health promotion information was provided in the waiting areas, which staff provided based on the needs of the local population. This included information on alcohol and smoking and signposting to groups such as a swimming club for people over the age of 50 and a local carer's network.

The practice's uptake for the cervical screening programme was 77% which was higher than the CCG average of 72% but lower than the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice uptake for bowel cancer screening in the last 30 months was 45% compared to the CCG average of 48% and national average of 58%. The practice uptake for breast screening for patients aged 50-70 in the last 36 months was 55% compared to the CCG average of 49% and national average of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 73% to 91% in comparison to the national expected coverage of 90%. The practice scored 8.6 out of 10 in the NHS England national comparator. Average MMR immunisation rates for both doses was at 90% compared to the CCG average of 83% and the national average of 91%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them 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 conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards which were all positive about the standard of care received. The general themes were that staff were friendly and caring and offered a personalised service. Patients said that receptionists were particularly welcoming and took the time to listen and understand patient's concerns. Ten patients noted they felt involved in their care planning and several patients commented they felt their appointments were interactive.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 87% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and the national average of 92%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 89% of patients said the last nurse they spoke to was good at giving them enough time compared to the CCG average of 88% and the national average of 92%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG and national averages of 87%.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received indicated people felt involved in decision making about their care. We also saw that care plans were personalised.

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:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 87%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.
- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 91%. The practice was aware this score was comparatively low and was prioritising the need for a permanent full time nurse as part of the practice team.

The practice provided facilities to help patients be involved in decisions about their care:

- Translation services were available for patients who did not have English as a first language. The practice had access to a telephone translation service and interpreters were invited to the practice at the patients' request. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format on request.
- Members of the patient participation group told us GPs asked about their wider health and social needs during appointments and did not just focus on the immediate health problem. This helped them to feel involved in their care and able to share concerns with GPs.
- We looked at eight care plans and patient records and saw documented evidence in each that care and treatment decisions had been discussed with the patient, or with a responsible person where they did not have mental capacity.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1.5% of its patients as carers. The team actively attempted to identify patients who were carers and advised them to receive the flu vaccine. Written information was available to direct carers to the various avenues of support available to them.

Where families suffered a bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a consultation at a flexible time to meet the family's needs and by giving them advice on how to find a support service.

The practice supported patients to access services to meet their emotional needs. This included a local intercultural counselling service and weekly on-site support from a Citizens Advice Bureau team who provided support to people from a minority ethnic background.

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 Clinical Commissioning Group (CCG) to secure improvements to services, for example in the care of young people who were prescribed antihypnotic medicine.
- GPs liaised with consultant psychologists as part of their holistic approach to care, which included an understanding that patients could find it difficult to express their needs.
- The practice followed national dementia friendly guidance from the Alzheimer's Society, including through staff training and regular health checks.
- Same day appointments were available for children, vulnerable patients and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were accessible facilities and translation services available.
- The practice ran dedicated clinics for a number of conditions, including diabetes, asthma, family planning, anticoagulation and cryotherapy.
- The practice provided services to people who were homeless, who lived in refuges, shelters and two local supported living facilities for young people with highly complex needs. Each patient was registered with a named GP, had an active care plan and received home visits, health checks and vaccinations. A GP provided an on-call service to these facilities, who could contact them directly. A GP also provided dedicated care to a cohort of displaced patients with refugee status.
- The practice staff spoke multiple languages and were able to provide ad-hoc support to patients as needed. In addition, where patients were known to be vulnerable or disempowered, including due to culture or religion, staff ensured an interpreter was available rather than expecting a family member to interpret for them. Staff also demonstrated a responsive approach to terminating appointments where they felt the relationship between family members was inappropriate.
- GPs held lead roles in specific conditions based on their professional interests and training. This enabled them to provided targeted support to patients with these conditions. This included a lead for chronic obstructive pulmonary disease and a lead for headaches and migraines.
- The lead GP for frailty worked as part of a specialist multidisciplinary team to meet the individual needs of people with multiple and complex needs and demonstrated they could respond urgently. For example, when a patient failed to attend an important hospital appointment, the GP visited them at home with a social worker. When the patient said they did not like the hospital they have been referred to, the GP immediately referred them to an alternative hospital.
- The practice participated in a six monthly domestic violence group that included reviews of at-risk patients and training for staff in recognising trafficking and female genital mutilation.
- There was evidence staff routinely sought to provide extended and individualised services to patients. For example, a GP worked with a social worker and care coordinator to conduct a joint home visit to an elderly patient considered to be at risk. As a result the multidisciplinary team was able to source a regular outreach worker and make the patient's home safer for them with the installation of a key safe. In another example a GP worked with teachers and parents from a local school that did not have access to a nurse to provide support to children with immediate health needs, including safeguarding needs.
- GPs worked with families to ensure care and support met their holistic needs, including where there were complex social care needs. For example, a GP liaised with social workers and a school when they identified a child at immediate risk. The GP worked with the family to improve the situation and provided the parent with the care they had needed.
- In response to high levels of asthma in the local population, the practice arranged for a specialist asthma nurse to be available in the practice weekly and provide pre-bookable reviews.
- A learning disability clinical lead was in post and provided individualised care, including with communication support, to patients on demand as well as annual health checks.
- A quiet breastfeeding room, child friendly waiting area and baby changing facility was available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

A local GP federation provided services seven days a week from 6.30am to 8.30pm Monday to Friday and from 8am to 8pm at weekends. Patients could see a GP outside of the practice who had access to their medical records and the same electronic system as the practice Outside of these hours cover was provided by the NHS 111 service.

We saw evidence that urgent, nurse and phlebotomy appointments were available the same day and routine GP appointments were available within one week. In addition any patients that walked in to the practice with an urgent need was seen on the same day.

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

- 71% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% national average of 76%.
- 58% of patients said they could get through easily to the practice by phone compared to the CCG average of 75% and national average of 73%. The practice had responded to this score by employing more reception staff and creating a dedicated call centre area in the building to improve response times to calls. The latest available data had been collected prior to the changes and so was not yet reflective of the improvements.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice designated a duty doctor each day to take responsibility for home visit requests and emergency appointments. The patient would be contacted by telephone to assess the risk. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

The practice monitored how patients accessed the service and adjusted services accordingly. For example, staff reviewed how patients accessed digital services and found 60% of access took place from a smartphone. To provide a better quality service for these patients, a GP upgraded the software used for the online platform to make it more accessible and user-friendly from smartphones.

Reception staff had training in recognising key words from patients calling the duty doctor so they could effectively prioritise calls. Emergency prescriptions were also available up to 5pm each weekday.

Listening and learning from concerns and complaints

The practice had an effective 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.
- The senior partner and deputy practice manager were the designated leads for handling complaints.
- We saw information was available to help patients understand the complaints system including a leaflet which was available in different formats for patient who needed additional assistance. The leaflet advised patients of alternative organisations to raise concerns if they were unhappy with the outcome of the complaint. These included the Parliamentary and Health Service Ombudsman, Healthwatch and the Independent Health Complaints Advocacy.

We looked at all 13 complaints received in 2016 and found these were satisfactorily handled and dealt with in a timely way with open and transparent communication. Lessons were learnt from individual concerns and complaints as well as from analysis of trends which was discussed during team meetings. We saw complaints were reviewed and evidence of actions taken as a result to improve the quality of care. For example, one complaint involved a patient who felt a clinical investigation was taking too long. As a result the GP contacted the patient and scheduled an immediate appointment and discussed the follow-up process with them to provide reassurance.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a mission statement and staff knew and understood the values and demonstrated these when providing care and services.
- The practice was developing a new business model and strategy and had appointed a new business manager to deliver this. This individual took up their post at the same time as our inspection.
- The practice planned to implement a full time permanent nursing post as a natural development of the part time locum post currently in place and was actively recruiting for this.
- New GPs said they felt immediately involved in the future strategy of the practice and were given freedom to identify what their part would be in that.

Governance arrangements

The practice had an overarching governance framework that 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. The practice was actively upskilling staff to ensure there was adequate cover in each role within the practice.
- Clinical meetings took place weekly and non-clinical staff joined the first half of each meeting to discuss joint topics.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained. The practice had achieved a high score for QOF points.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The practice had experienced a period of significant and sometimes unpredictable change. This involved the unplanned departure of the practice manager, the resignation of seven members of staff and one failed probation in a six month period. One member of staff returned to work in the practice. To ensure continuity of service, the remaining team worked to recruit to the vacant posts, establish a cohesive team and ensure morale was supported and promoted. The deputy practice manager worked up as a practice manager and was supported by the GP partners and four permanent reception staff were trained and promoted into administrator roles and helped with new staff inductions, training and support.

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 demonstrated how they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable, created an inclusive culture and always took the time to listen.

The practice invested in its staff and provided additional support where required to enable them to achieve individual goals such as with an apprentice who successfully completed their placement and achieved promotion over time into a senior administrative role.

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:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was a clear leadership structure in place and staff felt supported by the senior team.

- Administration staff met weekly with GPs to discuss significant events, complaints and any concerns.
- We spoke with trainee GPs who told us they felt consistently supported by partners and salaried GPs. They said arrangements for clinical supervision were effective and helped them to develop their skills in a

Are services well-led?

Good

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

very fast-paced surgery. Trainee GPs also said the whole team took responsibility for joint learning and support. For example, they had worked with the healthcare assistant to develop their skills in wound dressings.

- Salaried GPs told us although they were well supported they didn't feel that the practice had an overbearing hierarchy. This meant they felt able to develop, contribute to the running of the practice and contribute to an environment that valued challenge and improvement.
- Practice meetings were held monthly and each individual had the opportunity to contribute to the agenda in advance.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice and the partners encouraged staff to identify opportunities to improve the service delivered by the practice. We saw evidence that the practice was cross training staff members to ensure there was greater flexibility to cover various duties during staff absence.

Seeking and acting on feedback from 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 and design of the service.

- An established patient participation group (PPG) was in place. The PPG had eight core members and met every three months with practice staff, including with GPs. The practice demonstrated they listened to feedback from the PPG and implemented changes where possible. For example, the practice introduced a local-rate telephone number and a ticketing system for walk-in appointments to prevent queue-jumping. The PPG worked with the reception and administrative team to ensure information provided to patients was accessible and easy to understand. For example, PPG members reviewed a letter template and gave feedback that it was too complicated and used too many acronyms. As a result the letter was changed to ensure it was more understandable. The PPG produced a quarterly newsletter that was available in printed format in the surgery and electronically on the website.
- We saw evidence that the practice acted on the results of patient surveys. For example, the practice analysed results from the 2016 patient survey and implemented an action plan for areas of improvement. This included creating a call centre in the practice with additional non-clinical staff to improve response times to telephone calls. Staff also encouraged e-mail communication between patients and the practice to further reduce pressure on the telephone system. In addition, the reception team had undertaken cultural awareness training to help them communicate more effectively with the diverse patient group.
- The practice had gathered feedback from staff through regular team meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- As a result of feedback from the reception team, who were acting on what they observed and experienced with patients, a new emergency prescription service was introduced. This enabled patients to receive a prescription by 5pm provided they contacted the practice by 4pm.
- GPs had requested that the grace period for patients attending late be shortened from 20 minutes to 15 minutes to reduce delays for patients who arrived on time.

Continuous improvement

The practice valued staff development as a strategy to ensure the team was stable and continued to grow.

The practice proactively sought involvement with pilot schemes to expand and improve services. This included a 2015/16 pilot scheme to provide specialist mental health services on site. This scheme led to a permanent arrangement to host a psychologist, mental health nurse and community psychiatrist on site and enabled the practice to provide care and treatment for patients with complex mental health needs.

The practice had installed voice dictation software to every computer to facilitate more accurate note-taking and to

Are services well-led?

Good

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

improve efficiency for GPs without advanced typing skills. GPs told us this had improved the detail in their notes because it meant they could also now record psychosocial observations as well as baseline medical information.