The Ridgeway Surgery

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Outstanding**
Are services well-led?	**Good**

Overall summary

This practice is rated as Good overall. (Previous inspection 02/2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Good

We carried out an announced comprehensive inspection at The Ridgeway Surgery on 1 May 2018 as part of our inspection programme.

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 practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The most recent published QOF results showed the practice performed above local and national averages.
- The GP partners and management team were forward thinking. There was a strong commitment towards development and integrated care and the practice was involved in innovative projects both internally and within the locality.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients could access care at the main practice, branch surgery and a walk-in centre which was run by the practice. Some clinical staff worked across all three services which offered continuity of care for patients
- Feedback from patients and comment cards showed patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Data from the GP patient survey showed some patients reported difficulties getting through to the practice by phone and delays in the punctuality of appointments. The practice had reviewed patient feedback and implemented new strategies to improve these areas.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice supported members of staff to upskill and progress within their careers.
- There were systems to manage most risks within the practice. However, we found the process for monitoring emergency medicines at the branch surgery was not robust and some clinicians were not adhering to the practice's infection control policy.

We saw areas of outstanding practice:

- The practice employed two enhanced practice nurses who visited patients in their own home for a review. Triggers for a review included: admission to hospital on more than one occasion; increased frailty; new development of co-morbidities; becoming housebound; dementia; patients in the last phase of life; and carers. The practice had evidence to demonstrate the positive impact these nurses had on patient care. For example, case studies demonstrating positive outcomes for patients and a reduction in A&E attendances for patients over 75 years. The practice shared the concept of enhanced practice nurses with their locality group and four local practices agreed to appoint nurses for similar roles.
- The practice undertook a pharmacy project to improve communication with local pharmacies, improve patient care, and explore the educational needs of pharmacists and clinicians. The project developed into quarterly meetings with integrated multi-professional education for GPs and pharmacists and joint educational sessions with patients. Patients rated the educational session highly and the practice had seen an increase in the usage of repeat dispensing via the electronic prescription service. The practice shared learning from the project with the wider GP community and were presented with an award from Health Education England for Excellence in Education and Training in recognition of their work with local pharmacists.
- The practice worked with representatives of a local learning disability charity to improve health outcomes and access for patients with learning disabilities. Staff were given training and a representative was elected to the patient group committee. Improvements made as a result included: updating the learning disability annual review template; creating easy-read leaflets and

Overall summary

satisfaction surveys with pictures; and appointing a member of staff as learning disability champion. Learning from the scheme was shared at a local practice managers meeting.

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

- Review the systems in place for recording all significant events and monitoring emergency medicines.
- Review staff members' knowledge of infection prevention and control guidance relating to the disposal of urine samples.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to The Ridgeway Surgery

The Ridgeway Surgery is an NHS GP practice located in Harrow, Middlesex. The practice is part of NHS Harrow Clinical Commissioning Group (CCG) and provides GP led primary care services through a Personal Medical Services (PMS) contract to approximately 15,700 patients. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services).

We visited both the main practice and branch surgery as part of this inspection. Patients registered with the practice may attend either surgery.

Services are provided from:

- Main practice: 71 Imperial Drive, Harrow, Middlesex, HA2 7DU
- Branch surgery: Alexandra Avenue Health & Social Care Centre, 275 Alexandra Avenue , Harrow, Middlesex, HA2 9DX

Online services can be accessed from the practice website:

- www.ridgeway-surgery.co.uk

The practice is led by five GP partners (three male and two female) who are supported by: eight salaried GPs; three GP locums; four practice nurses; two advanced nurse practitioners; two extended practice nurses; two health care assistants; a practice manager; a reception manager; an administration manager; and 21 administrators / receptionists.

The age range of patients is predominantly 15 to 64 years and is comparable to the national average. The practice population is ethnically diverse with 46% Asian, 41% white, 6% black, 4% mixed race and 3% from other ethnic groups. The practice area is rated in the tenth deprivation decile (one is most deprived, ten is least deprived) of the Index of Multiple Deprivation (IMD).

The practice is registered with the Care Quality Commission to provide the regulated activities of: diagnostic and screening procedures; surgical procedures; and treatment of disease disorder and Injury.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse. However, some clinicians' were not following the practice's infection prevention and control protocols.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. The practice lead for safeguarding was also the CCG named GP for safeguarding children. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. A chaperone policy was in place and staff who acted as chaperones were trained for their role and had received a 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 took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was a system to manage infection prevention and control. However, we found some clinicians were not adhering to the practice's infection control protocol in respect of the disposal of urine samples. We brought this to the attention of the practice leaders and were assured this would be raised immediately with staff and rectified.
- The practice had arrangements to ensure that facilities and most equipment were safe and in good working order. Although calibration of the defibrillator at the branch surgery was overdue (due July 2017). The practice were aware of this and had made plans (documented on the risk register) for this equipment to be included in the annual calibration service in June 2018. In the interim, the practice could access a defibrillator from another healthcare provider who shared the same premises and we saw this equipment had been calibrated in April 2018.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, and busy periods.
- There was an effective induction system for staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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 including 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.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines. However, the process for monitoring expiry dates of emergency medicines at the branch surgery was not robust.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. However, although there was a system to check expiry dates we found out of date adrenaline ampules within the emergency medicines stock at the branch surgery. In

date adrenaline and other medicines were available for use in an emergency. During our inspection the practice removed the out of date adrenaline. Following our inspection the practice told us they had replenished the stock of adrenaline at the branch surgery and checked all emergency medicines at both sites to ensure they were within their expiry date.

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. We reviewed prescribing data and found the practice performed in line with local and national averages with the exception of prescribing antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) where prescribing was above local and national averages. The practice told us this data incorporated prescribing by the walk-in centre and did not solely reflect the practice population. Unverified practice data showed the practice were previously in the 99th centile for antibiotic prescribing and this had been reduced to the 33rd centile. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff we spoke with understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. However, whilst an example of a significant event described by staff had been acted on, it had not been recorded on the practice's template. Following our inspection the practice told us they planned to discuss this event at an upcoming practice meeting.
- There were adequate 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.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. This included cascading relevant information by email and discussing guidance during clinical meetings. 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' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients.
- 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. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for an annual health check only if they were on a practice register for their condition, on medicines that required monitoring, were carers, or under the enhanced practice nurse provision. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period 828 out of 1137 patients aged over 75 had received a health check.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual or biannual review (for patients with diabetes) 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 nursing team had lead roles in providing in-house care to patients with diabetes, asthma and COPD. Nurse-led diabetic clinics, including insulin initiation, were carried out with support from three GPs with additional training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Following an audit in this area the practice created a protocol which stated children would be seen within two days and adults within five days to ensure symptoms had improved and reinforce patient education.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention.
- People with suspected hypertension were offered ambulatory blood pressure monitoring and the practice had two monitors which could be loaned to patients.
- Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for some vaccines given were slightly below the target percentage of 90% (2016/17 data). The practice was trying to improve uptake rates by offering appointments out of school hours and identifying gaps in immunisation history for newly registered children. The practice had arrangements for following up failed

attendance of children's appointments following an appointment for immunisation. For example, a letter was initially sent and this was followed up by a telephone reminder.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Separate postnatal appointments for mother and baby were carried out to focus on maternal wellbeing.

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

- The practice's uptake for cervical screening was 62%, which was below the 80% coverage target for the national screening programme. The practice were already offering women appointments at different times; providing written reminders for patients to attend screening; and ensuring a female sample taker was available. Following our inspection the practice produced an action plan to improve uptake rates. This included reviewing the effectiveness of the current recall system; updating the website to include information in different languages and promoting pre-booked Saturday morning appointments at the walk-in centre; checking shared computer systems to identify if patients had undergone a smear at three local hospitals; working with the patient group to include information in the next newsletter; and organising a patient education event on cervical screening.
- There were failsafe systems 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's uptake for breast cancer screening was above the national average.
- The practice's uptake for bowel cancer screening was in line with the national average.
- 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 registers of patients living in vulnerable circumstances including: children in possession of a child protection plan; children whose parents have a high level increased need; children and young people with mental health needs; patients with a learning disability or mental health need that puts them at higher risk; patients with vulnerability associated with domestic violence; and homeless people. The register was reviewed quarterly during clinical meetings.
- There were 46 patients on the learning disability register and the practice looked after patients in a small residential home for people with severe learning disabilities.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 99% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those

living with dementia. For example, 95% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the national average.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

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. Clinicians took part in local and national improvement initiatives.

- The most recent published QOF results (2016/17) were 100% of the total number of points available compared with the clinical commissioning group (CCG) and national averages of 96%. The overall exception reporting rate was 5% (CCG 5%, national 6%) and clinical exception reporting rate was 4% (CCG 7%, national 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 used information about care and treatment to make improvements. For example, they reviewed their QOF performance on an ongoing basis to help ensure that they were focussing on patient care and reviews appropriately.
- The practice was actively involved in quality improvement activity. During the last two years, nine audits were carried out and four of these had second cycles to check improvements achieved. The areas for audit had been identified in discussion with practice leaders and in line with CCG and national priorities.
- We reviewed completed audits which confirmed the practice used these processes to help improve outcomes for patients. For example, an initial audit of all cancer diagnoses identified areas where changes could be made. The practice implemented these changes and carried out a second audit which showed the majority of patients presenting to the practice with symptoms and signs that could have been due to cancer were promptly and appropriately referred.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- 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 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.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making. Although we noted that a prescriber was not in attendance at the annual appraisal of an advanced nurse practitioner.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for the 147 housebound patients registered. They shared information with, and

Good

Are services effective?

liaised with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- 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 and copies were provided to patients.
- 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. Palliative care patients could access a bypass number to the practice and the palliative care team had direct access to some GP's mobile numbers.

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 own health. For example, through social prescribing schemes such as exercise and weight management support groups and foodbank voucher schemes. The practice also had a supply of free pedometers for patients to utilise.
- 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.
- Health information was provided on the practice website for patients fasting during Ramadan.

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. Verbal consent was currently obtained for minor surgery procedures such as joint injections. The practice told us they planned to implement written consent for these procedures going forward.
- 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.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Results from the GP patient survey showed that the practice performed comparably to or above local and national averages in relation to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- 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 carers and supported them.
- Results from the GP patient survey showed that the practice mostly performed comparably to local and national averages in relation to being involved in decision making.

Privacy and dignity

The practice respected patients' privacy and dignity.

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

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

The practice was rated as outstanding for responsive because:

- The practice understood the needs of its population and tailored services in response to those needs. In particular: the practice introduced the role of enhanced practice nurses to assist vulnerable patients who had difficulty accessing the service; patients had continuity of care as some clinical staff worked across the practice's two sites and the walk-in centre; communication between local pharmacists and the practice had improved and there were regular educational meetings to improve patient care; the practice had worked with a learning disability charity to improve the care for patients with a learning disability; the practice reviewed and implemented ways to improve access for patients; and there was a proactive patient participation group who worked closely with the practice to meet patients' needs and improve the service.

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 provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had reviewed ways to improve care for patients over 75, vulnerable patients who were predominantly housebound, patients with chronic conditions, and those recently discharged from hospital. They identified a 'gap' between the care provided by GPs and district nurses, more specifically that referrals to district nurses were for managing individual tasks with limited time to carry out a full review. The practice believed a nurse who could provide more time with these patients would be able to complete a full assessment and improve the care and health outcomes for these patients. The concept of an enhanced practice nurse (or link nurse) was shared with the locality group (seven practices) of which four practices agreed to appoint nurses for this role. The practice employed two enhanced practice nurses who collectively worked 37.5 hours. Their role was to visit patients who required additional care with the following criteria as triggers for review: admission to hospital on more than one occasion; increased frailty; new development of co-morbidities; becoming housebound; dementia; patients in the last phase of life; and carers.
- The practice had case studies demonstrating the positive impact the enhanced practice nurses had on patient care. For example, liaising with adult safeguarding teams to ensure patients were safely supported in their own home with external support. The practice also told us that the enhanced practice nurses had contributed to a reduction in A&E attendances for patients over 75. For example, unverified practice data showed that in 2014/15 (prior to the employment of enhanced practice nurses) 321 patients over the age of 75 attended A&E. This figure had reduced to 199 in the last 12 months (2017/18) despite a 7% increase in list size over the same time period.
- The facilities and premises were appropriate for the services delivered although the practice had plans to refurbish the main practice.
- Patients could access the walk-in centre which was managed by the practice and located at the same premises as the branch surgery. The walk-in centre was open from 8am-8pm on weekdays, weekends and bank holidays. Pre-bookable appointments with a nurse and health care assistant were available to practice patients on Saturdays. Some clinical staff worked at the practice, branch surgery and walk-in centre offering continuity of care for patients seven days a week.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- In 2014 the practice identified that efficiency in the prescribing system and communication between clinicians, local pharmacists and patients had deteriorated. The practice undertook a pharmacy project aimed at improving communication between local pharmacies and the practice; improving patient care; exploring the educational needs of pharmacists and clinicians; analysing the journey of a prescription and identifying problem areas; and implementing solutions and reviewing these changes. A GP partner

Are services responsive to people's needs?

took the lead and met with local pharmacies to initiate the project. An initial meeting took place and was attended by local pharmacy teams, the GP partners and prescribers within the practice. This developed into ongoing quarterly meetings with integrated multi-professional education. The outcomes from these meetings included: close working links with the patient group including a joint session on 'the journey of a prescription' to improve understanding of the system; pharmacists using NHS email addresses to improve communication; a bypass number for pharmacies to contact the practice; sharing of mobile numbers between pharmacists and clinicians; a better understanding of the skills of the pharmacists; and joint educational sessions covering topics such as dementia and asthma .

- Patients who attended the joint session rated the event as either nine or 10 (10 being excellent). In 2016 the practice and the local pharmacists won an award from Health Education England for Excellence in Education and Training as a result of this project. The practice also shared learning from the project at an annual GP conference.
- The practice actively promoted the use of online services for booking appointments and ordering repeat prescriptions. The number of patients registered for online access was 6759 (43% of patient list). Unverified practice data showed that in April 2017 21% of the practice's patients (the highest in the locality) utilised repeat dispensing via the electronic prescription service and this had increased to 32% (second highest in the locality) in May 2018. The pharmacy meetings were one of the reasons attributed to this increase.
- There was a well-established and proactive patient participation group (PPG) known as the Ridgeway Surgery Patient Group (RSPG) who worked in partnership with staff to keep patients updated on practice news, health education events (delivered by practice staff and guest speakers), training courses, fundraising events and health promotion. For example, since 2012 patients over 18 years could attend free cardiopulmonary resuscitation (CPR) and defibrillator training at the practice. There were eight training sessions held in 2017 and a total of 251 patients had been trained since 2012. A biannual newsletter was produced by the RSPG with input from the practice, and members of the RSPG personally delivered newsletters to patients who were unable to attend the practice. The RSPG had also funded equipment for the practice including a 24 hour blood pressure monitor, treatment couch, ear syringe, and an automatic blood pressure monitor for patients to utilise in the waiting room.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a 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 GPs and enhanced practice nurses also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual or biannual 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 monthly meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice and the RSPG organised educational talks on chronic conditions such as renal disease, diabetes, and osteoporosis. These talks were presented by practice clinicians or external experts such as local consultants.

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.
- The practice held monthly meetings with the health visiting team to discuss and manage the needs of vulnerable children.
- Parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice were the only surgery in Harrow to continue hosting weekly baby clinics alongside the health visitors, so that patients did not have to attend appointments in multiple locations.

Are services responsive to people's needs?

- The practice website contained a dedicated area for teenagers. This contained information on topics such as acne, eating disorders and period pains. There was also signposting to support organisations relevant to young people.

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, extended opening hours from 7:30am-8am Monday to Friday at the main practice and pre-bookable appointments at the walk-in centre during the weekend.
- Patients could email non-urgent messages to the practice including questions for a GP or to give feedback. The practice received approximately 500 email enquiries per year.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability. Patients on the register were deemed to require priority and easier access to clinical staff. The practice had assigned a colour code (red, amber or green) to these patients' record to assist staff in assessing the level of assistance required by the patient to access the service. For example, patients coded red were particularly vulnerable and it was likely they would have difficulty accessing the service therefore an on the day appointment should be provided and the on call doctor notified if there were any concerns. Patients coded green were still deemed vulnerable but it was unlikely they would have difficulty accessing the practice or clinical care. The guide for staff also highlighted that any patient they considered vulnerable (even those not flagged on the register) or in distress should be helped in accessing a clinician at any time.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. The practice had 33 patients registered as homeless. The practice had identified traveller families who frequently attended the walk-in centre and had now registered them with the practice.
- The practice was involved in a learning disabilities patient representative scheme with a local learning disability charity. Areas of focus included reviewing the annual care plan process and improving health outcomes and access for patients with learning disabilities. The representative, a member of the charity and a patient at the practice, received an induction at the practice and carried out training sessions for staff in 2016 and 2017. During the training sessions staff made pledges on how they would improve care and these were posted on a social media page for the charity. The representative attended the practice's patient group and was elected to the committee in 2017. Outcomes as a result of the scheme included: updating the learning disability annual review template to include preferred method of contact and a question to highlight the opportunity for the patient to speak with the GP alone if preferred; creating easy-read leaflets and satisfaction surveys with pictures; and appointing a member of staff as learning disability champion who would assist patients with booking their own appointment. Another patient with learning disabilities provided feedback via social media about the positive impact the scheme had on her care following staff training. The practice manager also shared learning, feedback and benefits of the scheme at a local practice managers meeting.

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.
- Patients who failed to attend appointments were followed up.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- The new patient registration policy included guidance on registering homeless people, temporary patients, and 'looked after children' (children looked after by the local authority). In response to a significant event where there was a delay in registering a new pregnant patient, the practice introduced a 'blue flag' registration policy to ensure same day registration and availability of appointments for the following groups: babies; pregnant women; elderly patients; looked after / foster /

Are services responsive to people's needs?

adopted children; patients with chronic illness; palliative care patients; and any vulnerable child or adult. The 'blue flag' registration criteria was displayed at reception.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Feedback from patients and comment cards showed patients found the appointment system was easy to use. Two out of eight patients we spoke with reported delays with the punctuality of emergency appointments.
- Results from the GP patient survey showed that the practice performed comparably to local and national averages in relation to timely access to care and treatment, with the exception of getting through to the surgery by phone and waiting 15 minutes or less after their appointment time to be seen.
- The practice were aware of patients' concerns regarding access and waiting times. In response to this they had created a notice for patients explaining why their appointment may be delayed. Reasons included the patient being consulted may have needed a longer appointment or required urgent admission/referral to another service, or the doctor may have been called away on an emergency or an urgent telephone call. Staff were also advised to promote double and triple appointments if necessary to reduce waiting times further.
- The practice had also reviewed ways to improve access to appointments on Mondays and had implemented a new system in February 2018 called 'triage Mondays'. This involved two GPs triaging appointment requests throughout the day and booking an appointment with the relevant clinician or resolving the matter over the telephone if appropriate. Staff were provided with detailed guidance on implementing the new system.
- As part of the introduction of triage Mondays, practice patients attending the walk-in centre whilst the practice were open were informed that a regular doctor at the branch surgery would call them to assess their symptoms before they were seen. This was because clinicians at the walk-in centre may not be able to fully assist patients with tasks such as referrals. A side room was provided for patients to take the call and a face to face consultation arranged if their concerns could not be resolved over the phone.
- Audits were undertaken to look at capacity and demand before and after the implementation of triage Mondays. One of the audits focussed on registered patients using the walk-in centre on Mondays to identify if the new system would benefit these patients in the future. The initial audit showed that 69 practice patients (13-18% of total patients seen) were seen at the walk-in centre over three consecutive Mondays in April 2017. A re-audit carried out 12 weeks after triage Mondays was introduced showed a reduction in the number of practice patients attending the walk-in centre on Mondays in April 2018 (24 patients, representing 3% of total patients seen). The practice also collected data on the monthly usage of the walk-in centre by practice patients. Unverified practice data showed this had reduced from 722 in April 2017 to 454 in April 2018.
- The practice planned to extend the new triage system to Fridays. Appointments on Tuesday to Friday were currently a mix of pre-booked appointments and time released urgent appointments and there was an on-call doctor available to triage during these times.
- The practice had reviewed other barriers to accessing care. For example, patients could have a blood test at the practice the same day their GP requested one.

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 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, a recall letter for a long-term condition review had been sent directly to a child and had caused distress to the child. This led to the practice changing the protocol for recall letters to exclude under 16s and to ensure letters to children aged under 16 were addressed to the patient or guardian. An apology was sent to the family.

Outstanding ☆

Are services responsive to people's needs?

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

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, capability and skills to deliver high-quality, sustainable care.

- Leaders 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.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values which were displayed in the staff meeting room. The practice had a realistic strategy 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.

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. This included implementing a 'being open policy' which detailed an open approach to communication of patient safety incidents to patients, families and carers.
- 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.
- 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.
- Clinical staff 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. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. 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 and the practice had a list of lead roles in respect of: safeguarding; infection prevention and control; data protection; safety alerts; QOF; prescribing; complaints; and health and safety.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, we found some staff were not adhering to the practice's infection prevention and control protocols.

Managing risks, issues and performance

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

Good

Are services well-led?

- 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 national and local safety 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 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.
- The practice had a proactive and committed patient participation group (PPG) called the Ridgeway Surgery Patient Group (RSPG). The group met up to six times a year and included representatives from various population groups. The group carried out annual surveys and collated patient feedback from events. The popularity of the educational events had increased and the RSPG had sourced a local church hall to be able to accommodate a larger group of people. The practice told us that a recent talk on dementia had over 100 attendees.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- The GP partners believed in long-term investment in the practice team and had supported members of staff to progress within their careers. For example, a health care assistant was now a practice nurse; a receptionist was now the practice manager; and an apprentice was now an administrator.
- There was a focus on continuous learning and improvement for staff at all levels. For example, the practice manager had received postgraduate management training and healthcare assistants had received additional training to increase their skillset and support the nursing team.
- The practice had expanded their clinical team to include a diverse skill mix. For example, GPs, practice nurses, advanced nurse practitioners, extended practice nurses, and healthcare assistants.
- Staff knew about improvement methods and had the skills to use them.
- 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.

Good

Are services well-led?

- The practice was a teaching practice for medical students and a training practice for registrars completing their GP training.
- The practice was involved in innovative projects internally and within the locality. For example, leading collaborative projects such as the pharmacy project and introducing the concept of enhanced practice nurses to the locality group.

Please refer to the Evidence Tables for further information.