Ridgmount Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 1 December 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- 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.
- Patients told us they had good access to the service and there was continuity of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about how to complain was available and easy to understand. Comments and complaints were analysed and 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.
- There was a clear leadership structure and staff felt supported by management.
- The practice was aware of and complied with the requirements of the duty of candour.

However, there was an area of practice were improvement should be made:

- The practice should continue with efforts to identify patients with caring responsibilities, so that they may offered and have access to appropriate support.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above local and national averages.
- The practice monitored performance and where the need for some improvement had been identified it had implemented actions.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits relating to relevant health issues were used to monitor quality and to make improvements.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed the practice was above the local and national averages in almost all aspects of care.
- Patients were very positive in this regard and told us 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.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice offered a walk-in service, provided by GPs and nurses, each weekday morning and afternoon. Evening and Saturday appointments were available at nearby practices under local working arrangements.
- Emergency consultations were available for children and those patients with medical problems which required urgent consultation.
- There were longer appointments available for patients with a learning disability, or who had long term or complex healthcare issues.
- Appointments could be booked online and by using a 24-hours automated telephone service.
- There were disabled facilities and all consultation rooms had step-free access. There were baby-changing and breast feeding facilities available.
- The practice proactively sought feedback from patients, which it acted upon.
- 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.

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 understood the vision and their responsibilities in relation to it.
- There was a strong leadership structure and staff felt supported by management. The practice had various up to date policies and procedures to govern activity.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The practice was aware of and complied with the requirements of the duty of candour. The partner GPs and practice manager encouraged a culture of openness and honesty.
- The patient participation group was active, although not representative of the patient list as a whole. However, a student representative did attend meetings.
- Staff members felt supported by management and were positive regarding their involvement in decision making.
- The practice's retention of staff was good and those we spoke with were very positive regarding their job satisfaction.
- The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- There was a strong focus on continuous learning and improvement at all levels.

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 the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people and made provision for urgent appointments for those with enhanced needs. Older patients were prioritised at the practice's walk-in clinics.
- The practice maintained a case management register of 326 patients at high risk of admission to hospital. Data showed there had been 50 unplanned admissions and all had been followed up within three days of notification of discharge.
- There was a complex care / frailty register of 10 patients, all of whom had up to date care plans.
- Records showed that 50 patients, being 76% of those who were prescribed five or more medications, had had a structured annual review since April 2016.
- Data showed that 20 patients identified as being at risk of developing dementia had received a cognition test or memory assessment.

People with long term conditions

Good

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

- The practice's performance relating to diabetes care was above local and national averages.
- The practice maintained a register of 87 patients with diabetes, of whom 90% had received an annual foot check and 70% had received an annual retinal check.
- The percentage of patients with diabetes on the register, in whom the last IFCCHbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2015 to 31/03/2016) was 80%, compared with the national average of 78%. The percentage of patients with diabetes on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2015 to 31/03/2016) was 85%, compared with the national average of 80%

Summary of findings

- Data showed the practice's performance relating to patients with atrial fibrillation (21 patients), hypertension (166 patients), chronic obstructive pulmonary disease (17 patients) and asthma (267 patients) was comparable with the national average.
- Nine out of ten patients with heart failure had had an annual medicines review.
- Longer appointments and home visits by GPs and nurses were available when needed.

Families, children and young people

Good

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

- For demographic reasons, the practice had low numbers of children on its patient list, but it had appropriate systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- There was a correspondingly low number of under-five year olds, with the take up rates for standard childhood immunisations being generally comparable with averages.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The premises were suitable for children and babies, with baby changing facilities.
- Children aged under-5 attending the practice were prioritised to minimize waiting.

Working age people (including those recently retired and students)

Good

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

- The practice was proactive in offering online services that reflects the needs for this age group, including online registration for students.
- Walk-in clinics were run by GPs and nurses each weekday morning and afternoon.
- Evening and Saturday appointments were available at nearby practices under local working arrangements.
- Telephone consultations were available and patients could correspond by email over non-urgent healthcare issues.
- The practice's uptake for the cervical screening programme was comparable with averages.

Summary of findings

- Data showed that 237 patients aged over-16 had been offered health checks and 153 (65%) had been carried out; 483 patients (97% of those eligible) had undergone blood pressure checks in the last five years.
- The practice offered a full range of health promotion and screening, including chlamydia, for patients aged under-25, and HIV testing.
- One of the GPs specialised in sports medicine.
- We saw evidence of close and effective liaison with University College London, concerning the healthcare needs of students who make up a large proportion of the patient list.

People whose circumstances may make them vulnerable

Good

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

- The practice had few patients from this group on its list. Patients with a learning disability had received an annual follow up and the care plans were up to date.
- The practice offered longer appointments for patients with a learning disability.
- Homeless patients could register with the practice's address to access healthcare and welfare services.
- A number of patients lived at a hostel, and the practice offered referral to local services, such as self-help groups, alcohol and drug misuse services and domestic violence support.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- The percentage of patients diagnosed with dementia (six patients) whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2015 to 31/03/2016) was 100%, compared with the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Summary of findings

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses (46 patients) who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 88%, comparable with the national average.
- Data showed that 78% of patients with severe mental health problems who receive annual physical health check in last 12 months.
- Continuity of care for patients experiencing poor mental health was prioritised.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice worked closely with University College London, relating to students' mental health issues. It had a specific risk protocol and provided patients with an information sheet containing guidance and the contact details of support organisations.

Summary of findings

What people who use the service say

The latest national GP patient survey results available at the date of the inspection had been published in July 2016. The results were consistently above local and national averages, although the sample group was comparatively low - 369 survey forms were distributed and 30 were returned. This represented just 0.18% of the practice's list of approximately 16,000 patients.

- 100% of patients found it easy to get through to this practice by phone, compared to the local average of 76% and the national average of 73%.
- 86% of patients were satisfied with the surgery's opening hours, compared to the CCG average of 72% and the national average of 76%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried, compared to the local average of 84% and the national average of 85%.
- 91% of patients described the overall experience of this GP practice as good, compared to the local average of 84% and the national average of 85%.
- 89% of patients said they would recommend this GP practice to someone who has just moved to the local area, compared to the local average of 79% and the national average of 78%.

We discussed the small survey sample with staff and we were shown the most recent results of the practice's own annual patient survey. This had last been conducted in March 2016, with a higher return rate: 400 questionnaires had been issued, with 185 patients responding (1.15% of the list). The results substantiated those of the GP patient survey.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 comment cards, and spoke with six patients together with three members of the patient participation group. The patients said they were very satisfied with the care they received and thought staff were approachable, committed and caring. Almost all of the 15 patient comment cards we received were very positive about the service experienced, although one card stated that during busy times, the "doctors can be too quick". Patients were generally very happy with access to the service, particularly the walk-in clinics. However, two patients told us and one comment card mentioned that routine appointments could involve a two-week wait; one added that they always saw their preferred GP. Another patient said that appointments available via the online booking facility were limited. The three members of the patient participation group were very positive regarding the engagement of the practice.

We saw the most recently published data from the Friends and Family Test. This showed that of 670 responses submitted up to November 2016, 80% of patients said they were likely to recommend the practice, with 7% saying they were unlikely to recommend it.

Areas for improvement

Action the service SHOULD take to improve

- The practice should continue with efforts to identify patients with caring responsibilities, so that they may offered and have access to appropriate support.

Ridgmount Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Ridgmount Practice

The Ridgmount Practice operates from 8 Ridgmount Street, London WC1E 7AA. It moved to the newly built / refurbished premises in April 2016. It had formerly been known as the Gower Place Practice. The premises are located close to Goodge Street, Euston Square and Tottenham Court Road underground stations and there are good bus services nearby.

The practice provides NHS services through a General Medical Services (GMS) contract to approximately 16,000 patients. Many of the patients are university students and there are seasonal variations according to the academic year, with several thousand patients leaving or joining the patient list. A significant number of the students are foreign nationals, with Chinese patients making up the largest group among them. The patient profile shows that the number of patients in the age range 17-24 years is significantly higher than average, at 68% of the list; patients aged between 25 and 34 years make up 25% of the patient list, which is higher than average; the number of patients below-16 (0.3%) and over-35 (6%) is significantly below the average. The deprivation score for the practice population is in the fourth "more deprived decile", indicating a slightly higher than average deprivation level among the patient group.

The practice is part of the NHS Camden Clinical Commissioning Group (CCG) which is made up of 35 general practices. It is registered with the Care Quality Commission to carry out the following regulated activities - Diagnostic and screening procedures; Maternity and midwifery services; Family planning; Treatment of disease, disorder or injury.

The practice's clinical team is made up of three partner GPs (one female and two male); five female salaried GPs; three nurse practitioners and a practice nurse. The three partners and two of the salaried GPs each work on average eight clinical sessions per week; the other salaried GPs each work an average of four clinical sessions per week. One of the salaried GPs was on long-term leave and cover was being provided by a locum GP. Two of the nurse practitioners work fulltime; the third and the practice nurse are part-time.

The administrative team of nine is comprised of a practice manager and assistant manager, an IT administrative assistant, two secretaries, a reception manager and three receptionists.

The practice opens between 9 am and 5.30 pm, Monday to Friday. The practice is closed at weekends and has opted out of providing an out-of-hours service. Telephone calls are answered by the practice between 9 am and 5.30 pm. Between 8 am and 9 am and between 5.30 pm and 8.30 pm, Monday to Friday, calls are put through to the out of hours provider. Between 6.30 pm and 8 am, calls are routed initially to NHS 111, and may also be passed through to the out-of-hours provider in appropriate circumstances.

Routine appointments are 10-15 minutes long, although patients can book double appointments if they wish to discuss more than one issue or, for example, if an interpreter is needed. Appointments for reviewing long term conditions are 30 minutes long. If they have previously registered for the system, patients can book or cancel

appointments and request repeat prescriptions online. The practice also has a 24-hour system for booking appointments by phone, for patients without online access. Patients who have provided their mobile numbers and consent are sent text message reminders of their appointments. Emergency home visits are available for patients who for health reasons are not able to attend the practice.

In addition, the GPs provide a triaged walk-in service each morning between 9.30 am and 10.30 am and each afternoon between 2.30 pm and 3.30 pm. The nurses also operate a walk-in service between 9 am and 11 am each morning and between 2 pm and 4 pm each afternoon.

Evening appointments, at another location in south Camden, can be booked by the practice reception staff at a patient's request. In addition, a number of Saturday appointments are available under a local scheme operating at three locations across the borough.

There is information given about the out-of-hours provider and the NHS 111 service on the practice website, together with details of a local walk-in clinic, which any patient can attend.

Why we carried out this inspection

We carried out a comprehensive inspection of the practice 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.

The practice had not been inspected previously.

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 1 December 2016. During our visit we:

- Spoke with a range of staff including partner GPs, a nurse practitioner and practice nurse, the practice manager and members of the administrative team. We also spoke with six patients who used the service, and three members of the patient participation group.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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. These included actual incidents and near misses.

- The practice had a policy for recording incidents, managing any investigation, analysis and for recording the outcomes. The policy, which included the reporting form, was accessible on staff members' computers and had last been reviewed in November 2016. Staff we spoke with were familiar with the protocol and reporting form and described how these were used. One of the partner GPs led for significant events. We saw several examples of and noted these were well-recorded and detailed. Events were reviewed at weekly clinical meetings; if of particular significance they were discussed straight away. Information, including the results of investigations, was disseminated to staff by email.
- The incident management process 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.
- 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 to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, there had been seven incidents treated as serious adverse events in the past 12 months, these included new cancer referrals and other clinical cases of note. We discussed several of them with staff. In one case, a patient had fainted in the waiting area and were attended to by reception staff, one of the nurses and a GP. The patient was assessed and arrangements were made for them to get home safely. The incident was reviewed by staff later in the day, with discussion on how patients may become confused if feeling unwell, and that events may occur quickly and unexpectedly, requiring prompt action by staff. The response of staff to the incident was commended. We saw clinical meeting minutes confirming discussion on another significant event, involving a patient with a rare health condition, which set out appropriate learning points for staff. The case had been well-managed.

Patient safety alerts, received using the NHS Central Alerting System, and for example relating to particular medications, were received by all clinicians. The practice manager collated and maintained records of all alerts received in a hard copy folder. When medications alerts were received, the administrative team ran a search of computer records, to identify which patients had been prescribed the drugs, who were then contacted accordingly. We saw evidence of recent alerts, including one issued by the Medicines and Healthcare products Regulatory Agency (MHRA) in November regarding Hydrocortisone 100mg/1ml Solution for Injection, a steroid used to treat inflammation due to a number of diseases and conditions; and a patient safety alert regarding the "Risk of death and severe harm from error with injectable phenytoin", an anti-seizure medication. We also saw that general prescribing issues were discussed at clinical meetings to ensure safe practice and that risks to patients was minimised.

Overview of safety systems and processes

The practice had clearly defined and embedded systems and processes in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. One of the partner GPs was the lead for adult safeguarding and child protection and they had a named deputy. The vulnerable adults safeguarding policy had been reviewed in April 2016, with the child protection policy being reviewed in July 2016. The practice also had a policy on Female Genital Mutilation, reviewed in November 2016. When the policies had been reviewed, they were emailed to all staff, who were required to sign a record sheet confirming they had read them. The policies were filed on the practice's shared drive, accessible to all staff for quick reference. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. We saw evidence of safeguarding procedures being reviewed and discussed at clinical meetings. The GPs attended

safeguarding meetings when possible and always provided reports where necessary for other agencies. The practice maintained a register of vulnerable patients; there were ten such patients at the time of our inspection, with one patient on the practice's learning disabilities register. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The clinical team of GPs and nurses were trained to safeguarding level 3. The administrative staff were trained to level 1.

- Notices in the waiting area and consultation rooms advised patients that chaperones were available if required. The practice website also mentioned chaperones being available on the appointments page. The practice policy, which had been reviewed in January 2016, was available to all staff on the practice computer system. Three of the nurses and some of the administrative staff performed chaperone duties and had received appropriate training and repeat Disclosure and Barring Service (DBS) checks had been carried out. (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.) The remaining nurse and several other administrators were to be trained in early 2017. We interviewed several staff members and discussed chaperoning. They had a clear understanding of the issue and their duties when acting as chaperones.
- The practice maintained good standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Cleaning was undertaken in accordance with written cleaning schedules and checklists, posted in each room. Clinical staff were responsible for cleaning their rooms during the day. One of the practice nurses was the clinical lead working closely with the practice manager on infection prevention and control issues. All had received appropriate level training and we saw records evidencing that all staff received regular refresher training. It was also an area covered by the staff induction process. The practice liaised with the local infection prevention teams to keep up to date with best practice. The infection control policy, together with the policies relating to clinical waste and general waste management, had been reviewed in April 2016, when the practice moved in to the new premises. The practice carried out regular infection control audits. We saw records of the last one, and noted it contained an appropriate action plan to address any highlighted issues. We saw that disinfectant gel was available and hand washing guidance was provided by posters throughout the premises; we were shown the results of a recent hand cleaning audit. Clinical waste was stored in a secure container in an area not accessible by the public, and was collected weekly and disposed of by a licensed contractor. The practice had an in date sharps injury protocol, accessible on the shared computer system, and guidance notices advising on procedures relating to sharps injuries available in the treatment and consultation rooms. Disposable curtains were used in the GP's consultation rooms and had a note affixed of when they had been put up and were due to be changed. The practice had spillage kits and a sufficient supply of personal protective equipment, such as surgical gloves, aprons and masks. The practice staff we spoke with were aware of the appropriate procedures to follow should there be the need use the spillage kits. Equipment, such as spirometer and nebuliser, was cleaned and maintained in accordance with a written schedule and the manufacturer's recommendations. All medical instruments were single-use. A record was maintained of all staff members' Hepatitis B immunisation status.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe including obtaining, prescribing, recording, handling, storing, security and disposal. Processes were in place for handling repeat prescriptions. These included the review of high risk medicines, with flags on patients' records to assist in monitoring their prescribing. The practice's repeat prescribing policy had been reviewed in April 2016; all repeat prescriptions were generated by GPs. Uncollected prescriptions were monitored and the cases reviewed every two months. 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 for safe prescribing. The practice benchmarked its prescribing practice using data provided by the CCG. We saw that Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The use of PGDs was in accordance with current guidelines. The practice monitored and recorded stocks of medicines and vaccines every four weeks. During our discussion with

staff, they agreed to carry out the monitoring every two weeks. Supplies were reordered on a regular basis to avoid a build-up of stock if it was unused for a significant period; all those we saw were within date and fit for use. The GPs' home visits bag was stored securely in the medicines cupboard. The vaccines fridge temperatures were monitored and recorded.

- We reviewed the personnel files of four staff and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We noted that staff turnover was very low.

Monitoring risks to patients

Risks to patients were assessed and well managed. The practice manager was the named lead for health and safety issues. A full fire risk assessment had been carried out in April 2016, when the practice first moved to the premises. This included an inspection of firefighting equipment and emergency lighting. A fire drill was conducted in June 2016; the fire alarm was tested weekly. The fire safety policy had been reviewed in November 2016. Most staff had completed fire safety training, with it having been booked for the remainder; 13 staff were trained fire marshals. Health and safety risk assessments were repeated every two months. The annual inspection and calibration of medical equipment had been carried out in December 2015 and we saw that the 2016 inspection had been booked. The annual inspection of portable electrical appliances (PAT Testing) had been done in July 2016. The fixed wiring and boiler had been checked and certified before the premises handover in April 2016. A legionella risk assessment had been carried out at the same time. Legionella is a bacterium which can contaminate water systems in buildings. The practice had a management plan in place, under which regular water sampling was done, together with water temperature monitoring. The practice had a variety of other risk assessments in place to monitor safety at the premises, for example relating to the Control of Substances Hazardous to Health (CoSHH). There was CCTV coverage throughout the premises, allowing staff to monitor health and safety risks and security.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. The emergency protocol had been reviewed in August 2016 and the emergency incident policy in November 2016.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received annual basic life support training in 2016 and guidance was posted in all consulting rooms.
- The practice had a defibrillator available on the premises, with the pads in date and the battery charged ready for use. The practice had an emergency oxygen supply, a first aid kit and an accident recording book was used. Staff told us the equipment was checked on a monthly basis, but agreed it would be done more frequently henceforth.
- The practice had a range of emergency medicines which were monitored by practice nurses and were easily accessible to staff in a secure area of the practice; all staff knew of their location. All the medicines we checked were in date and stored securely. Supplies were logged and monitored.
- The practice had a detailed business continuity plan in place. The plan had been reviewed in November 2016 at the same time as the emergency incident policy. It contained emergency contact numbers for stakeholders, utilities providers and contractors. The plan provided for the service to re-locate temporarily should the premises be put out of use because of fire, flooding or power-cuts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards. These included National Institute for Health and Care Excellence (NICE) best practice guidelines and those issued by the Camden CCG.

- The practice had systems in place to keep all clinical staff up to date and to provide them with information to help deliver care and treatment that met patients' needs. One of the partner GPs was the practice lead for receiving and disseminating clinical guidance, which was logged onto the practice's computer system and emailed to staff. The guidelines and alerts were also printed and added to a central library file, which could be accessed by all staff, as well as by any locums. We saw that NICE guidance was also covered by newsletters from the Camden CCG, which were distributed to all staff and discussed. Recent examples included "Mental health problems in people with learning disabilities" (NG54); "Supporting people with dementia and their carers" (CG42); and "Multimorbidity" (NG56). We saw that clinical guidance was discussed at weekly clinical meetings, for example NICE guidance NG28, relating to diabetes care and updated in July 2016, had been discussed at a clinical meeting in August, when all clinical staff were instructed to familiarise themselves with the guidance.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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 recently published results related to 2015/16 and were 98.6% of the total number of points available being 3.4% above the CCG average and 3.2% above the national average. The practice's clinical exception rate was 7%, which was 0.4% below the CCG average and 2.8% below the national average. 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 that cannot be prescribed because of side effects.

Data from 2015/16 showed:

- Performance for diabetes related indicators was 97.8%, being 7.8% above the CCG average and 7.9% above the national average.
- Performance for hypertension related indicators was 100%, being 3% above the CCG average and 2.7% above the national average.
- Performance for chronic obstructive pulmonary disease was 100%, being 3.1% above the CCG average and 4.1% above the national average.
- Performance for asthma was 100%, being 4.1% above the CCG average and 2.6% above the national average.
- Performance for mental health related indicators was 99.5%, being 7.6% above the CCG Average, and 6.6% above the national average.

There was evidence of quality improvement including clinical audit to highlight where improvements made could be monitored. They included ones that had been initiated by the practice as well as a number by the local CCG. There had been 12 clinical audits carried out in the last 12 months. Of these, two were completed-cycle audits and three were ongoing repeated annual audits. We looked at a completed-cycle audit relating to patients prescribed oral nutritional supplements (ONS or sip feeds) which are liquid formulations containing a range of nutrients, to supplement or provide the complete nutritional requirements for a patient. The results showed improvement as follows: the percentage of patients who had tried non-prescription supplements had increased from 17% to 60%; the percentage who were prescribed supplements on an acute basis, rather than having repeat prescriptions had decreased from 83% to 60%; the percentage whose prescriptions included full instructions on dosage instructions and the timing of treatment had increased from 50% to 60%; and the percentage prescribed the most cost-effective in line with local prescribing requirements had increased from 67% to 100%.

We saw that the practice worked very closely with University College London, particularly in relation to students' mental health issues. It had a specific risk protocol and provided patients with an information sheet containing guidance and the contact details of support

Good

Are services effective?

(for example, treatment is effective)

organisations. Three clinical psychologists attended the practice for a session each week, offering three sessions per week in total, and the practice had access to other specialists to whom patients could be referred. We saw several good examples of the care and support the practice provided in relation to patients' mental health needs.

Effective staffing

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

- We saw the practice's recruitment policy and procedure, which had been reviewed in July 2016, and included a detailed process for recruitment including carrying out appropriate background checks, seeking references, evidence of training and professional qualifications and registration. It also set out the induction procedure for new staff, appropriate to their role, including introducing staff to the practice and its governance arrangements, and providing training on such topics as basic life support, equality and diversity, fire safety, infection control, information governance, moving and handling and safeguarding children and adults. All new staff were subject to a six-month probationary period.
- The practice prepared rotas for clinical staff six months in advance, allowing for planned absence to be covered appropriately.
- Few locum GPs were used; but, when needed, regular locums with past experience at the practice were booked. There was a detailed information pack for them to use.
- The practice could demonstrate how it ensured role-specific training and updating for relevant staff; with recent examples being epilepsy and diabetes care, domestic violence, and sexual health.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence. Staff who administered vaccines stayed up to date with changes to the immunisation programmes, for example by access to on line resources, yearly updates and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months, and training objectives were recorded.
- Staff received training that included: safeguarding, fire safety awareness, basic life support, and information governance. Staff had access to and made use of a range of e-learning training modules and in-house and external training. The practice manager maintained records of staff training needs and was able to easily monitor and identify when refresher training was due; we saw evidence of various forthcoming refresher training sessions being booked. Staff had protected learning time.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. We saw several examples on various patients' records which we reviewed with clinical staff.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice used systems, such as Co-ordinate My Care and the Camden Integrated Digital Record ("CIDR") to share information with other providers involved in patients' care.
- We saw examples of special patient notes, used to share appropriate information with the out of hours service provider, urgent care centres and the local ambulance service.

Staff worked together and 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. The practice held multidisciplinary team meetings (MDTs) on a monthly basis. Participants included, district nurses, health visitors, social workers, psychology and mental health professionals and the palliative care team. The practice followed the Gold Standards Framework programme for palliative care, with one of the salaried GPs being the named lead.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. The process was set out in the practice's consent protocol, last reviewed in April 2016, which we saw.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance. Staff had received training which included guidance on the Mental Capacity Act 2005 and we saw refresher training was booked for the New Year.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Staff were able to demonstrate a familiarity with children's capacity to consent to treatment, which included consideration of the Fraser Competence Guidelines, relating to contraceptive or sexual health advice and treatment.
- The practice computer system contained appropriate templates for use in establishing patients' mental capacity to consent and to record action taken in the patients' best interest.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to the relevant service. This included patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The practice had identified the smoking status of 99% of patients aged over-16 on its list. Records showed that 1,832 patients were current smokers and the practice had offered smoking cessation advice to 1,147 (63%) of the identified smokers in the last two years.

The practice's uptake for the cervical screening programme was 81%, the same as the national average. There was a policy to offer telephone reminders for all patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme for those with a learning disability and it 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 also encouraged its patients to attend national screening programmes for breast and bowel cancer screening. Its results for breast cancer screening were above the local average and for bowel cancer screening they were comparable with the local average.

The practice had very few children aged under-two years on its list. Accordingly, the childhood immunisation rates for the vaccinations given to under-two year olds, which ranged from 50% to 75%, being below the national average, were not representative of the practice's overall performance. The practice immunisation rate for children aged five on the list was 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 16-65 years. Data showed that 237 patients aged over-16 had been offered health checks and 153 (65%) had been carried out. Data also showed that 483 patients (97% of those eligible) had undergone blood pressure checks in the last five years. 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 very 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; 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.
- Phone calls were handled by staff away from the waiting area, maintaining confidentiality.

Almost all of the 15 patient comments cards we received and the nine patients we spoke with were very positive about the service experienced, although one card stated that during busy times, the "doctors can be too quick". The comment cards and the patients we spoke with highlighted that staff responded compassionately when they needed help and provided support when required. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

The practice's satisfaction scores recorded by the GP patients' survey on consultations with GPs and nurses were generally above the local and national averages. For example -

- 90% 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%.
- 93% of patients said they had confidence and trust in the last GP they saw, compared to the CCG average of 94% and the national average of 95%.
- 90% 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%.
- 100% of patients said the last nurse they saw or spoke to was good at listening to them, compared to the CCG average of 87% and the national average of 91%
- 97% of patients said the last nurse they saw or spoke to was good at giving them enough time, compared to the CCG average of 88% and the national average of 92%
- 97% of patients said they had confidence and trust in the last nurse they saw or spoke to, compared to the CCG average of 96% and the national average of 97%
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern, compared to the CCG average of 87% and the national average of 91%.

In addition, 97% of patients said they found the receptionists at the practice helpful, the figure being 10% above both the CCG and national averages.

We noted that the sample group responding to the GP patient survey was very small - 30 patients responded, representing roughly 0.18% of the practice's list of approximately 16,000 patients.We discussed this with staff and were shown the results of the practice's own 2015 / 16 patient survey. This was a larger sample, involving 185 patients. The survey included questions relating to patients' overall satisfaction with their consultation with GPs and nurses, and specifically to clinicians listening to them, explaining issues, respect shown, time given and reassurance offered. The results were very positive throughout and consistently showed satisfaction rates in excess of 95%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey regarding patients' involvement in planning and making decisions about their care and treatment were above local and national averages. For example -

Good

Are services caring?

- 91% of patients said the last GP they saw was good at explaining tests and treatments, compared to the CCG average of 86% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care, compared to the CCG average of 82% and the national average of 82%.
- 97% of patients said the last nurse they saw or spoke to was good at explaining tests and treatments, compared to the CCG average of 85% and the national average of 90%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care, compared to the CCG average of 82% and the national average of 85%.

The results were borne out by those of the practice's own in-house patient survey.

The practice provided facilities to help patients be involved in decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language. In addition, staff members spoke various languages, including Mandarin, Spanish and French, and were able to assist patients whose first language was not English. We saw that the practice had written leaflets in various languages giving details of NHS and local services. The website also had information in other languages, as well as a simple facility for translating the whole site.

Patient and carer support to cope emotionally with care and treatment

There were notices and patient leaflets waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs when a patient was recorded as being a carer. The practice had identified 28 patients as carers, less than 0.2% of the practice list. This was mainly due to the profile of the patient group, which was principally of patients aged between 17 and 34 (approx. 93%) and predominantly young adults of student age (68%). The number of patients younger than 16 years (0.3%) and over-35 years (6%) was significantly below the average. However, the practice should continue with efforts to identify patients with caring responsibilities, so that they may be offered and have access to appropriate support. The practice had produced a carer's pack and there was written information available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them by post, offering a face-face or telephone consultation. We saw examples of this mentioned in clinical meeting minutes. We saw that information about bereavement and support services was available on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered a walk-in service, provided by GPs and nurses, each morning and afternoon, allowing brief consultations regarding patients' recently developed healthcare issues. Older patients and children under-5 using this triaged service were prioritised.
- Emergency consultations were available for children and those patients with medical problems which required urgent consultation.
- There were longer appointments available for patients with a learning disability, or who had long term or complex healthcare issues.
- Home visits by GPs were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Telephone consultations were available for working patients.
- Patients could email GPs regarding non-urgent issues.
- There were accessible facilities and all consultation rooms had step-free access. There were baby-changing and breast feeding facilities available.
- Interpreting services were available and the practice had an induction loop to assist patients with hearing impairment.
- Appointments could be booked, and repeat prescription requested, online. Appointments could also be booked using a 24-hours automated telephone service.
- Students living in halls of residence could register for the practice online.
- Text reminders were sent to those patients who had provided their mobile number and consent.

Access to the service

The practice opened between 9 am and 5.30 pm, Monday to Friday. The practice closed at weekends and had opted out of providing an out-of-hours service. Telephone calls were answered by the practice between 9 am and 5.30 pm. Between 8 am and 9 am and between 5.30 pm and 8.30 pm Monday to Friday, calls were put through to the out of hours provider. Between 6.30 pm and 8 am, calls were routed initially to NHS 111, and might also be passed through to the out-of-hours provider in appropriate circumstances.

Routine appointments were 10-15 minutes long, although patients could book double appointments if they wished to discuss more than one issue or, for example, if an interpreter was needed. Appointments for reviewing long term conditions were 30 minutes long. If they had previously registered for the system, patients could book or cancel appointments and request repeat prescriptions online. The practice also had a 24-hour system for booking appointments by phone, for patients without online access. Patients who had provided their mobile numbers and consent were sent text message reminders of their appointments. Emergency home visits were available for patients who for health reasons are not able to attend the practice.

In addition, three or four GPs provided a triaged walk-in service each morning between 9.30 am and 10.30 am and each afternoon between 2.30 pm and 3.30 pm. This service was designed for brief consultations regarding patients' recently developed healthcare issues. The nurses also operated a walk-in service between 9 am and 11 am each morning and between 2 pm and 4 pm each afternoon. Older patients and children under-5 were prioritised at the walk-in clinics.

Evening appointments, at another location in south Camden, could be booked by the practice reception staff at a patient's request. In addition, a number of Saturday appointments were available under a local scheme operating at three locations across the borough.

There was information given about the out-of-hours provider and the NHS 111 service on the practice website, together with details of a local walk-in clinic, which any patient can attend.

The patients we spoke with and the comment cards we received were all very positive regarding the walk-in clinics operated by GPs and nurses. However, two patients told us and one comment card mentioned that routine appointments could involve a two-week wait; one added that they always saw their preferred GP. Another patient said that appointments available via the online booking facility were limited.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The results of the GP patient survey, which showed the practice's scores regarding access were above average, for example -

- 86% of patients were satisfied with the surgery's opening hours, compared to the CCG average of 72% and the national average of 76%.
- 100% of patients found it easy to get through to this practice by phone, compared to the CCG average of 76% and the national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 84% and the national average of 85%.
- 90% of patients said their last appointment they got was convenient, compared with the CCG average of 88% and the national average of 92%
- 85% of patients usually getting to see or speak to their preferred GP, compared to the CCG average of 53% and the national average of 59%.

We noted from the practice's own patient survey results, involving 185 patients, that 83% of those responding said they had seen a GP or nurse within 24 hours. This included those using the walk-in service. It also showed that 20% of the patients had made use of the practice's online facilities, which the practice was looking to increase.

The practice had arrangements in place to cover particularly busy periods, such as the beginning of the academic year when many new patients registered. For example, special evening and weekend registration sessions were arranged and staff were limited in leave taking during busy times.

The premises were leased by University College London from a private landlord and the practice occupied them under a sub-tenancy. The premises were newly-refurbished and designed for purpose; the practice had moved in in April 2016. The practice was responsible for routine internal maintenance, although most of the fittings and services were still under the contractor's warranty. We had positive feedback from patients regarding the improvement in facilities, compared to the old premises. The practice occupied three floors, all of which were accessible by a lift. There were two treatment rooms on the ground floor, used occasionally when patients had severe mobility issues. Otherwise, they were used for the various counselling services that operate at the practice. The reception and main waiting area was on the first floor, together with the three nurses' rooms. There were six GPs' consultation rooms on the second floor, with a smaller waiting area.

Listening and learning from concerns and complaints

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

- Its complaints policy, which had been reviewed in November 2016, and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person, who handled all complaints in the practice. They were assisted by the associate practice manager.
- We saw that information was available to help patients understand the complaints system. There were notices posted around the premises and complaints information was given on the practice website.

We saw that four written complaints and one verbal complaint had been submitted to the practice in the last 12 months. The complaints were satisfactorily handled, dealt with in a timely way, with openness and transparency. They were closely monitored and discussed at weekly clinical meetings and whole-staff meetings every two months. We saw they were reviewed on an annual basis, and anonymised summaries were shared and discussed with the patient participation group. The complaints were analysed in detail to identify any trends and action was taken to as a result to improve the service and quality of care. We looked at one of the complaints made by a patient who had attended a walk-in clinic. The clinic was particularly busy, so one of the nurses offered to triage the patients attending. The nurse suggested to the patient that as their healthcare issues were long-term they would best be dealt with at a longer routine appointment. The patient was unhappy with this. The practice manager spoke with the patient, offering apologies and invited them in to explain procedures and discuss their concerns. The patient was content with the apology and the explanation given. We saw that the complaint was discussed at the following staff meeting, so that learning could be shared. The practice would continue to have nurses carry out triaging at busy times, with the process being clarified on waiting room screen and the website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

In addition to dealing with formal complaints, the practice also monitored comments left by patients on the NHS Choice website. Those making complaints were invited to contact the practice for an appointment to discuss their concerns.

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. Its statement of purpose statement was set out on its website -

- To provide excellent quality of service to all our patients with an environment which is confidential, safe and welcoming.
- To respect our patients and fully involve them in all decisions of their health care and treatment.
- To treat all equally and with respect irrespective of ethnic origin, religious belief, sexual orientation or nature of their health problems.
- To encourage our patients to be involved in practice decisions and planning through our Patient Participation Group and surveys.
- To focus on prevention of diseases and health promotion.
- To work effectively in partnership with other health care professionals.
- To support our staff and ensure they have the right skills and training to provide the best care for our patients and ensure their own wellbeing.
- Have zero tolerance to all forms of abuse and request that patients show the same level of respect to our staff which is afforded to them.

Staff we spoke with were aware of the statement and supported it.

Governance arrangements

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

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice-specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- The practice monitored the results of the GP patients' survey, together with the Friends and Family Test. It checked and responded to reviews left by patients on the NHS Choices website and ran its own patient surveys.
- A programme of clinical and internal audit relating to relevant health issues was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partner GPs demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. We were told they prioritised safe, high quality and compassionate care. Staff told us the partner GPs and practice manager were approachable and always took the time to listen to all members of the practice team.

The practice 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 partner GPs and practice manager encouraged a culture of openness and honesty.

The practice had effective systems in place to ensure that when things went wrong with care and treatment -

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

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

- The clinical team met formally on a weekly basis. The partner GPs and practice manager met separately, every week, and there were whole-staff meetings every two months.
- 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.

Are services well-led?

Good

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

- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the provider and practice management encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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 of the service. There was suggestions box in the reception area and the practice website had a facility to submit comments and suggestions online. The practice analysed complaints it directly received, as well as comments left by patients on the NHS Choices website. The practice had conducted its own annual patient survey, most recently in March 2016, just prior to moving to the new premises The results had been predominately positive results and the practice had drawn up an action plan to address issues that had been highlighted. These included providing patients more opportunity to speak with GPs and nurses by phone. The practice had previously trialled a telephone clinic, but uptake had been limited. With the move to the new premises, the more available space had allowed the practice to provide nine extra clinical sessions per week, affording more opportunity for telephone consultations. Patients would be asked for their views during the next scheduled survey. Issues relating to the waiting room had also been addressed following the premises move. There was also action taken to increase patients' use of online facilities. Two additional screens had been obtained which ran three extra videos promoting online services; reception staff were encouraged to inform patients of the online services; and the online patient registration service for students had been launched in September 2016.

We spoke with three members of the PPG, who were very positive regarding the engagement of the practice. Meetings were held quarterly, which an average of eight members attending. The practice provided full administrative support. Anonymised summaries of complaints were shared with the PPG to allow monitoring of performance. Members told us the group had been very much involved in identifying new premises and discussing and agreeing its design. It was recognised that the PPG was not representative of the patient group as a whole, although we did note that a student representative attended meetings. The PPG and the practice had sought to increase participation by younger patients, but the high annual turnover had hampered this. Members attended wider forums, allowing feedback relating to the Camden CCG overall.

The practice had gathered feedback from staff through staff meetings, appraisals and general discussion. 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. All the staff we spoke with commented on the close team-working culture and support they got from the partner GPs, practice manager and their colleagues. The practice arranged frequent social events for staff, which were popular. The practice's retention of staff was good and those we spoke with were very positive regarding their job satisfaction.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. Staff had protected learning time. One of the salaried GPs had recently been accredited as a trainer and the practice was exploring the option to become a training practice. The practice had supported nurses in qualifying as nurse practitioners. One of the receptionists told us they had requested training relating to domestic violence and this had been arranged.

The practice participated in local quality improvement projects, including those relating to dementia prevalence, epilepsy and diabetes care, including working with a specialist diabetes nurse employed by the CCG, and setting up virtual clinics for patients with diabetes.