Golborne Medical Centre

Quality Report

12-16 Golborne Road
Ladbroke Grove
London
W10 5PE
Tel: 020 8964 4808
Website: www.golbornemedical.nhs.uk

Date of inspection visit: 15 February 2018
Date of publication: 25/04/2018

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

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Goldborne Medical Centre on 15 February 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.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The practice had added to the services it provided in response to the recent Grenfell fire and the specific needs of its patient group.

We saw one areas of outstanding practice:

- The practice had developed a Reflective Interprofessional Education Network (RIPEN) which was an inclusive thematic collaborative learning community for sharing experiences, developing innovations, providing patient centred holistic care.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The six population groups and what we found

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

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

Golborne Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and an expert by experience.

Background to Golborne Medical Centre

Golborne Medical Centre is located in a residential area of Kensington and Chelsea, west London, it is in the joint most deprived Ward in London and the second most deprived Ward in the UK. The practice is co-located in premises which are shared with another GP practice, with wheelchair access and all patient areas are on the ground floor. The practice has a total patient list size of approximately 2542 patients.

Their address is: 12-16 Golborne Road, Ladbroke Grove, London, W10 5PE.

Website: www.golbornemedical.nhs.uk

The practice team is made up of two GPs (one male, one female) providing 12 sessions per week, a part time nurse, two healthcare assistants one full time and one part time, a My Care, My Way senior case manager and health and social care assistant, a diabetes nurse consultant and a nurse educator all part time. The practice also has a practice manager, three receptionists and a patient support facilitator.

The practice is a teaching practice and had no student doctors at the time of inspection.

The practice is open between 8am to 6.30pm Monday to Friday, with an extended hour's service on Thursdays from 6.30pm and 7.30pm and between 9am to 1.15pm on Saturday.

There are also arrangements to ensure patients receive urgent medical assistance when the practice was closed. Out of hours services are provided by a local provider. Patients are provided with details of the number to call.

The practice serves a diverse population with many patients attending where English is not their first language. The practice population is 49% non-white minority ethnic groups. Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. People living in more deprived areas tend to have greater need for health services.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

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

Risks to patients

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

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

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

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

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

Track record on safety

The practice had a good safety record.

Good

Are services safe?

- 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 that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were 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. For example; when a patient incorrectly had a request for a home visit refused by a receptionist it was discussed with all receptionist staff and the home visiting policy explained in an administration meeting, that all calls are put through to the duty GP or trained practice nurse for triage.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used a virtual lifestyle application called Ourpath for patients unable to attend daytime health promotion classes to help them manage their health better.
- The practice used a text message system to remind patients about upcoming appointments and to invite patients to participate in health initiatives such as flu immunisation.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice were involved in developing a Reflective Interprofessional Education Network (RIPEN) which was an inclusive thematic collaborative learning community for sharing experiences, developing innovations, providing patient centred holistic care. This facilitated resource sharing between secondary and primary care.
- The practice offered patients over 65 the My Care, My Way integrated care service. It had been designed by local patients and GPs is a multi-organisation collaboration led by NHS West London Clinical Commissioning Group. My Care, My Way exists specifically to support the health and wellbeing of local people who were aged 65 and over to help keep them well, closer to home.
- The service referred patients who may be socially isolated to nearby Second Half Centre who provided over 60 hours of activity a week. Activities ranged from physical exercise classes such as Bokwa and stretch & tone, to creative arts, which included mosaics and painting, languages, computer courses and more (Bokwa participants draw letters and numbers with their feet while performing a cardio workout routine).
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice used a Virtual Lifestyle app called Ourpath to help patients manage conditions such as diabetes.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 82% compared to the CCG average of 77% and the national average of 78%.
- The percentage of patients with Chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 97% compared to the CCG average of 89% and the national average of 90%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions was 85% which was comparable to the CCG average of 78% and the national average of 76%.

Families, children and young people:

- The practice held weekly walk in baby clinics for antenatal, post-natal checks and immunisations.

Good

Are services effective?

(for example, treatment is effective)

- The Health visitor held monthly meetings in the practice for child safeguarding and service updates.
- The practice participated in monthly paediatric MDT clinics with Consultant Paediatricians which helped to manage the health of young people in Primary Care and integrate with other services.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. For children under two years of age, four immunisations were measured; each had an uptake target of 90%. The practice had not achieved the target for two of the four areas and the practice score ranged from 69% to 92%. Childhood immunisation rates for vaccines given to five year olds ranged from 90% to 95%, these were comparable to the national averages which ranged from 88% to 94%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice was open six days per week Including Thursday evening and Saturday mornings.
- There was online access to book appointments, online consultations and patients could request repeat prescriptions through the practice website.
- The practice's uptake for cervical screening was 67%, which was in line with the 80% coverage target for the national screening programme. This was comparable to the CCG average of 56% and the national average of 72%.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU) was 0.14 which was lower than the CCG average of 0.96 and the national average of 0.90 (The volume of prescribing is measured in average daily quantities. For a given drug, the average daily quantity is a value calculated to reflect the daily dose typically prescribed to individual patients within UK General Practices.

A STAR-PU is a value calculated to reflect not only the number of patients in a practice, but also the age and sex mix of that group).

- 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 co-ordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people and travellers.
- The practice maintained a learning disabilities register of eight patients, seven of whom had received an annual follow up and had their care plans reviewed.
- The practice worked with local alcohol and drugs support teams

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

- 100% (of 5) of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is higher than the national average of 84%.
- 84% 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 of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 95%; CCG 91%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 97%; CCG 94%; national 95%).
- In the last 12 months the practice had organised specialist in house training on Cognitive-behavioural therapy (CBT), Trauma & Anger management. Their practice manager has undertaken extra mental health training.

Monitoring care and treatment

Good

Are services effective?

(for example, treatment is effective)

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 95% of the total number of points available compared with the clinical commissioning group (CCG) average of 92% and national average of 96%. The overall exception reporting rate was 5% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. 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 by clinical audit. The practice had carried out nine clinical audits in the last 12 months. One we reviewed was to improve achievement of three Treatment Target outcomes in the population to reduce mortality, morbidity in people with Diabetes and reduce variation in care (the three treatment targets are blood pressure, blood glucose control and cholesterol from the National Institute for Health and Care Excellence). The first cycle of the audit showed that 13% of patients were meeting this target. The clinical team reviewed the results and made a number of changes, including employing a diabetes specialist nurse for two hours a week for the patients who needed support with insulin titration and uncontrolled HbA1C. Increasing patient education on the importance of the three Treatment Target, care planning and goal setting, monthly network benchmarking meetings were organised and knowledge shared. The second cycle of the audit a year later showed that 31% of patients were meeting this target which was an improvement and higher than the CCG average of 21%.
- The practice was actively involved in quality improvement activity. The practice was developing into a Training practice and they have a focus on education, for example, the lead GP and the nurse educator had designed a new HCA course for diabetes to upskill and support their teams which included mentoring and input from dieticians and podiatry. This was for West London CCG (WLCCG) and to be shared as a model with the other seven North West London CCGs.
- Where appropriate, clinicians took part in local and national improvement initiatives. The lead GP is the diabetes champion/transformation lead for WLCCG and engaged and visited other practices to share ideas about improved working.

Effective staffing

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

- The practice 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 Care Certificate was officially launched in March 2015. It aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care). The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- 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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when

Good

Are services effective?

(for example, treatment is effective)

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- The practice used "co-ordinate my care" to share up to date care plans for palliative patients with relevant agencies, with patient consent, to ensure care was tailored to the patients' needs when the surgery was closed.
- The practice co-ordinated care with My Care, My Way for over 65's. This included weekly meetings for proactive case management in an MDT setting with Case Manager, Health & Social Care Assistant and named GP and longer flexible appointments at the practice.

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.
- Percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway was 75% which was higher than the CCG average of 50% and the national average of 52%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 36 patient Care Quality Commission comment cards we received were positive about the service experienced, patients felt they were treated with dignity and respect, that the reception staff were helpful and felt that the doctors always gave them enough time. however one mentioned difficulty in getting appointments and another a complaint which they felt was dealt with well. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 378 surveys were sent out and 90 were returned. This represented about 4% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 90% of patients who responded said the GP gave them enough time; CCG - 84%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 96%.
- 97% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 87%; national average - 86%.
- 88% of patients who responded said the nurse was good at listening to them; (CCG) - 87%; national average - 91%.
- 89% of patients who responded said the nurse gave them enough time; CCG - 88%; national average - 92%.
- 94% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 94%; national average - 97%.
- 90% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 87%; national average - 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers, their computer system alerted GPs if a patient was also a carer. The practice had identified 69 patients as carers (2.7% of the practice list).

- There were leaflets for the various services who support for carers in the reception area.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services caring?

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

- 95% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 92% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 87% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 84%; national average - 90%.
- 83% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 80%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- We saw that patients' confidentiality was well-managed in the reception area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example the practice offered extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The local CCG had organised specialist in house training on Cognitive-behavioural therapy (CBT), Trauma & Anger management. The practice manager has undertaken extra mental health training. The Mental Health prevalence had been compounded by the serious incident of the Grenfell Fire. As well as flexibility in appointments including extra evenings and weekends, they had set up a bespoke CBT clinic for those affected by Grenfell and others who may benefit, with an MDT with the GP to review cases to provide comprehensive care.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

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

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice is leading on design and rollout for the diabetes MDT to the other North West London CCG's.
- The practice used a Virtual Lifestyle app called Ourpath to help patients manage conditions such as diabetes.
- The practice focused on prevention through promotion of healthy lifestyles.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The health visitor ran monthly meetings in the practice for child safeguarding and service updates

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

- Extended opening hours were offered on Thursday evenings and Saturday morning.
- 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 and Saturday appointments.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice ensured patients could register easily, had alerts on their computer system to highlight the need of those in this group, offered physical health screening, immunisations and extra time.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- The practice had organised specialist in house training on Cognitive-behavioral therapy (CBT), Trauma & Anger management for patients who had been affected by the Grenfell Fire.
- The practice were closely involved in the local hospital's Ethnographic Research to understand patients' needs around mental health and long term conditions. A new service was designed based upon these findings for the practice population with Diabetes with Improving Access to Psychological Therapies (IAPT) (Ethnographic research is a qualitative method where researchers observed and/or interacted with a study's participants in their real-life environment.)

Timely access to the service

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

- 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.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was at or above local and national averages. This was supported by observations on the day of inspection and completed comment cards. 378 surveys were sent out and 90 were returned. This represented about 4% of the practice population.

- 93% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 82% and the national average of 80%.
- 96% of patients who responded said they could get through easily to the practice by phone; CCG – 84%; national average - 71%.
- 81% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 78%; national average - 76%.
- 85% of patients who responded said their last appointment was convenient; CCG - 81%; national average - 81%.
- 79% of patients who responded described their experience of making an appointment as good; CCG - 77%; national average - 73%.
- 50% of patients who responded said they don't normally have to wait too long to be seen; CCG - 64%; national average - 64%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Five complaints were received in the last year. We reviewed all five complaints and found that they were satisfactorily handled in a timely way.
- 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; when a patient felt ignored and uncomfortable with receptionist, the patient complained, the practice wrote to the patient and apologised. The patient was happy with the response and as a result the practice designed a patient questionnaire to identify training areas and ways to

Good

Are services responsive to people's needs?

(for example, to feedback?)

improve front of house. A training skills matrix was developed to help and support the administration and reception teams with ongoing monitoring and performance management by the practice leadership.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

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

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

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.
- 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, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

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 including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

Are services well-led?

Good

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

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

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example; the practice had acted on a patient participation group (PPG) suggestion to have a call screen in reception to display services and health information.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. The practice had helped to develop a Reflective Interprofessional Education Network (RIPEN) which was an inclusive thematic collaborative learning community for sharing experiences, developing innovations, providing patient centred holistic care.
- The practice offered patients over 65 the My Care, My Way integrated care service. It had been designed by local patients and GPs is a multi-organisation collaboration led by NHS West London Clinical Commissioning Group.
- The practice was leading on design and rollout for the diabetes MDT to the other North West London CCG's.
- The practice used a Virtual Lifestyle app called Ourpath to help patients manage conditions such as diabetes.
- 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.