Wide Way Surgery

Inspection report

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

Ratings

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

Overall summary

This practice is rated as Outstanding overall. (Previous rating 8 October 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Wide Way Surgery on 7 August 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out in line with our next phase 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.
- The practice understood the needs of its population and tailored services in response to those needs. There was evidence of a number of projects and services the practice had been involved with to ensure patients' needs were met.
- 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 and engagement with external organisations to improve the quality of services delivered for practice patients and the local population.

We saw areas of outstanding practice:

- The practice had developed a number of bespoke protocols and 'intelligent' templates on the electronic record system which included automated prompt messages for care plans, referral forms and direct links to guidance and local services, so that GPs were able to ensure patients received standardised, up to date and timely care and treatment at the point of need. There was evidence that these tailored systems had been shared with and formally adopted by the Clinical Commissioning Group (CCG) and sent to all CCG practices.
- The practice had initiated and developed the proposal for an improved approach to diabetes care and worked with in the local community healthcare NHS trust to deliver this. The proposal was piloted in the practice before being piloted in the three other Primary Care Home (PCH) practices. As part of the project, a diabetes 'academy' meeting was set up for staff education and sharing ideas; the lead GP arranged accredited diabetes training for 13 staff across the PCH practices and the practice developed systems to ensure close monitoring for complex diabetic patients. The project involved directly bookable diabetes clinics with a community specialist diabetic nurse via remote email, telephone and joint consultations. Unverified data showed that outcomes for diabetic patients had improved over the last year as a result. The project was in the process of being developed across CCG practices.
- The practice identified the need for additional primary care input into a local care home to improve outcomes for older people. As part of this project, the practice strengthened their systems which ensured older people with frailty received effective care and treatment. The six-month pilot project of weekly ward rounds, joint working and improved access commenced in December 2017. Data from the CCG compared with the previous year showed that after the pilot, the care home had dropped from the first to the fifth highest ambulance conveyor and the number of ambulance conveyances had reduced from 46 in 2017 to 12 in 2018 after the pilot, which was a 74% reduction in ambulance service use by the care home. As a result of this pilot, the scheme had begun to be rolled out CCG wide.
- A social prescribing project which was particularly utilised by vulnerable patients, had produced a reduction in both the number of GP appointments and accident and emergency (A&E) visits by these patients. One of the partners developed the social prescribing model for the CCG. The practice then volunteered to be involved in a local CCG pilot model of Social Prescribing aimed to connect medical care with local voluntary and community resources. Social prescribing appointments

Overall summary

were delivered by a Social Prescribing Coordinator (SPC) two days per week. Across the first three months of the project, 138 patients visited two practices for social prescribing appointments (approximately 104 patients from Wide Way Surgery). The pilot saw a significant increase in health and wellbeing for patients as well as significant decreases in both number of GP appointments (by 543) and A&E attendances (by 29 visits) in patients referred to the service. Patients reported better self-management as a result of the scheme. From April 2018 the social prescribing programme was rolled out across nine GP practices in the CCG.

- The practice provided innovative services to support staff and foster a positive culture including staff awards, a daily coffee 'debrief' session, three times weekly chair yoga sessions and a well-being services package for staff. The practice was the first practice in South West London to provide additional well-being services for staff.
- The practice had undergone a £1 million premises expansion and redevelopment, which was completed in 2018, partially funded by the practice.
- The practice had initiated and led the creation of the first collaborative working Primary Care Home site in South West London. The lead GP partner was the chair of the local GP collaborative primary care home and the managing partner was the director of the organisation. The practice had been approached by neighbouring London CCGs for advice and sharing their experience of developing primary care at scale. The practice invested time and knowledge to lead the primary care home collaborative, which resulted in improvements in services to benefit the practice population.
- The practice successfully wrote a bid on behalf of the CCG to be part of the NHS England Clinical Pharmacist Programme. The bid led to funding for four clinical pharmacists, one for each PCH practice. The practice continued to drive the Clinical Pharmacist Programme locally, providing clinical and managerial leadership.

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

- Further develop quality improvement systems to include monitoring and analysing trends from verbal patient feedback.

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

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

Older people	**Outstanding** ☆
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	**Outstanding** ☆
People experiencing poor mental health (including people with dementia)	**Good** ●

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Wide Way Surgery

The registered provider of the service is Wide Way Surgery. The address of the registered provider is 15 Wide Way, Mitcham, Surrey, CR4 1BP. The practice is registered as a partnership of four partners with the Care Quality Commission to provide the regulated activities of diagnostic and screening services, family planning services, maternity and midwifery services and treatment of disease, disorder or injury. One further partner is due to apply to be added to the provider's registration.

Regulated activities are provided at one location operated by the provider. The practice website is https://www.widewaymedicalcentre.nhs.uk/your-surgery/.

Wide Way Surgery provides services to 9400 patients in Mitcham, Surrey and is one of 23-member practices of Merton Clinical Commissioning Group (CCG). The practice provides services to one local care home.

The practice has a higher than national average population of children and young people and a lower than local and national average number of those over 65. Deprivation scores are higher than local and national averages and deprivation affecting children is considerably higher. The practice is in the 5th most deprived decile in England. Of patients registered with the practice, approximately 41% are White or White British, 34% are Black or Black British, 17% are Asian or Asian British, and 8% are other or mixed ethnic backgrounds.

Wide Way Surgery operates from a purpose built medical centre, comprising 13 consulting rooms, one treatment room, administrative rooms and a patient waiting area. The surgery is accessible to those with mobility problems. The medical centre also houses other community health services including a local GP access hub for Merton CCG. On the first floor there are dental, midwifery, health visitor, sexual health and family planning services available from other providers.

The practice held a service level agreement with the local extended access hub who shared the premises and were able to access practice equipment and medicines.

There are four part-time GPs who are partners and two part-time salaried GPs. Patients are able to see male or female GPs. The nursing team consists of a full-time advanced nurse practitioner, three part-time practice nurses and a part-time health care assistant. The practice employs a phlebotomist, one part-time clinical

pharmacist and a second pharmacist has been recently recruited. In total the medical team provides the equivalent of 45 sessions per week via a skill mix of GPs, pharmacists and the nurse practitioner.

The clinical team is supported by a managing partner, four administrative staff and eight reception staff. A social prescriber works at the practice one day per week.

Out of hours, patients are directed to the local out of hours provider for Merton CCG via 111.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

- At the previous inspection in 2015, we identified concerns with monitoring vaccine refrigerator temperatures. At this inspection we found that all the systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment were safe and minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- The practice were in line with local and national averages for antibiotic prescribing and they had actively worked to reduce antibiotic prescribing by in line with national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

Good

Are services safe?

The practice learned and made improvements when things went wrong.

- 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. Each incident was assigned to a partner to review and the managing partner oversaw the process. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- Significant incident forms were available electronically and these could be accessed directly via the patients' records to improve accessibility and encourage reporting.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.
- External quality alerts were submitted to the Clinical Commissioning Group (CCG) where the practice identified quality and safety issues linked to incidents involving secondary care services.

Please refer to the evidence tables for further information.

Good

Are services effective?

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

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' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had developed a number of bespoke protocols and 'intelligent' templates on the electronic record system which included automated prompt messages for care plans, referral forms and direct links to guidance and local services, so that GPs were able to ensure patients received standardised, up to date and timely care and treatment at the point of need. There was evidence that these tailored systems had been shared with and formally adopted by the Clinical Commissioning Group (CCG) and sent to all CCG practices.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice held registers for patients with frailty, community case management, care home patients, housebound patients and those receiving end of life care.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. The practice had identified 145 patients with severe frailty and 428 with moderate frailty. All moderate and severe patients had received reviews. The 90 patients assessed as most severe with additional needs were also case managed and monitored closely. One of the partners had developed a frailty long-term condition protocol for the patient electronic record system, which was adopted by the CCG for use in other practices.
- The practice provided medical services to a local care home which experienced high numbers of ambulance conveyances to accident and emergency. The clinical model for the care home pilot, developed by one of the partners, was based on nationally recognised recommendations for frailty. As part of this project the practice had completed health checks for all 35 residents. Health checks included a tailor made holistic GP care plan including advanced care planning.
- A clinical pharmacist undertook medicine reviews including polypharmacy reviews for those over 75 on five or more medicines. So far 50% of those identified had been completed.
- The practice held a multi-disciplinary team meeting every two months with community services and district nurses.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual 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.
- There were clear GP and nurse leads for a range of long-term conditions. Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Clinical staff followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary

disease (COPD), atrial fibrillation and hypertension. The practice used computer software to identify electronic record coding errors to proactively identify undiagnosed long-term conditions.

- The practice's performance on quality indicators for long term conditions was mostly in line with local and national averages. However, the practice had identified that performance for one of the diabetes indicators was lower than averages indicating that some patients with diabetes were not being reviewed effectively. The practice had analysed performance data and local population health data and implemented a project to improve treatment and monitoring for these patients which included working with the local community healthcare NHS trust to deliver an approved approach to diabetes care. Unverified data showed that outcomes for diabetic patients had improved over the last year as a result, and they developed systems to ensure complex diabetic patients requiring focused intervention were closely monitored.
- A clinical pharmacist was employed by the practice to specifically undertake diabetic reviews.

Families, children and young people:

- Childhood immunisation uptake rates were mostly below the target percentage of 90%. The practice were aware of the lower childhood immunisation rates and had undertaken a practice analysis of immunisation uptake rates. An action plan was in place to improve uptake and a number of actions had already been achieved.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. All failed attendances for both secondary care and practice appointments were monitored by GPs.
- The practice held specific safeguarding meetings every two weeks.

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

- The practice's uptake for cervical screening was 65%, which was below the 80% coverage target for the national screening programme. The practice were aware of this and had undertaken a detailed analysis of cervical screening performance data and implemented an action plan to address issues found, including a women's health corner in the practice to promote uptake.
- The practice's uptake for breast and bowel cancer screening was below the national average. The practice were aware of this. They had a planned patient education session on bowel screening for August 2018.
- 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. Unverified practice data showed that 75% of those invited for NHS health checks were completed between 2013-2018.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- There was a clinical lead for learning disabilities. Practice data showed that there were 27 patients on the learning disabilities register and 100% had received a review for 2017/18. The templates used on the electronic record system had direct links to signpost patients and carers to local resources.
- The practice had undertaken health checks for 75% of patients on the carers register. Specific carers' protocols were used on the electronic record system which included depression screening and if the carer was a child.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Vulnerable patients were able to access appointments with a social prescriber who signposted patients to a range of community and voluntary services to meet their non-medical needs.
- All non-attenders of secondary care appointments and practice appointments were audited and followed up by GPs to ensure patients were not at risk.

Good

Are services effective?

- The practice held specific safeguarding meetings every two weeks.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medicines.
- The practice's mental health register had proactively increased from 63 to 94 patients.
- The mental health lead GP attended a quarterly multi-disciplinary team meeting with the local community mental health team.
- Data showed that the practice were significantly lower prescribers of medicines that aid sleep. They had improved patient education and provided sleep hygiene advice sheets to reduce reliance on sleeping tablets.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- There were 65 patients on the practice's dementia register.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Dementia templates routinely included advanced care plans.
- A dementia-link nurse attended multidisciplinary team meetings every two months.
- The practices performance on quality indicators for mental health was above local and national averages.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. There were examples of clinicians taking part in local and national improvement initiatives.

- The latest published overall Quality and Outcomes Framework (QOF) results showed that the practice was above local and national averages. However, the clinical exception reporting rate was higher than local and national averages at 12%. (Exception reporting is intended to allow practices to achieve quality improvement indicators without being penalised for patient specific clinical circumstances or other reasons beyond the practice's control.)
- Unverified data obtained from the practice showed that overall, QOF achievements for 2017/18 had improved, particularly in relation to diabetes, despite an increased prevalence in diabetes from 440 to 660 patients.
- We found that there were systems designed to monitor and improve quality of care to ensure that patients were monitored appropriately including clear exception reporting protocols and the use of computer software to automatically identify any data coding issues and patients at risk of long-term conditions.
- The practice used information about care and treatment to make improvements. The practice had initiated projects to address key areas where performance issues were identified and had implemented action plans. They had experienced common themes contributing to areas of lower performance in 2016/17 including an unstable and reduced practice nursing team and a considerable increase in patient list size. Quality improvement projects included those for improving cervical screening uptake, improving childhood immunisation uptake, reducing cervical smear inadequate rates, and improving monitoring of diabetic patients.
- The practice was actively involved in quality improvement activity including clinical audit. There had been five clinical audits over the last two years, three of these had two or more audit cycles demonstrating ongoing and sustained improvements in quality of care.
- Clinicians took part in a number of local and national improvement initiatives in response to health inequalities and the practice was a key player in initiating projects on behalf of the GP collaborative.

Effective staffing

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

- Staff had appropriate knowledge for their role, for example, to recognise the signs of sepsis, to carry out reviews for people with long term conditions, older people, people experiencing poor mental health and people requiring contraceptive reviews.

Good

Are services effective?

- 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.
- Staff were undertaking specific training in diabetes.
- There was an effective skill mix of staff including a clinical pharmacist, a phlebotomist, a social prescriber, a nurse practitioner and a care co-ordinator.
- 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. All staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- The practice was a teaching practice for medical students and a training practice for trainee GPs.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- Systems for handling patient information including results, letters and referrals were streamlined and well-managed.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Multi-disciplinary team meetings occurred every two months with attendance from the district nursing teams, social worker and community pharmacist, quarterly with the community mental health team and every two months with the dementia link nurse.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- 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.
- There was a well-being lead GP and the practice actively advertised signposted patients to a local lifestyle advisory service.

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.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results were above or in line with local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and two of the population groups: older people and people whose circumstances make them vulnerable, as outstanding for providing responsive services.

The practice was rated as outstanding for responsive because:

- There was evidence that a care home pilot project had reduced ambulance conveyances to accident and emergency which resulted in positive outcomes for older people.
- A social prescribing project which was particularly utilised by vulnerable patients, had demonstrated a reduction in both the number of GP appointments and accident and emergency visits by these patients.

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 clearly understood the needs of its population and tailored services in response to those needs. There was evidence of a number of projects and services the practice had been involved with to ensure patients' needs were met.
- The practice had experienced a rise in the patient list size by 31% between 2016 and 2018. They had secured additional resources via internal investment and external funding to meet patients' varied and complex needs, including a social prescriber, two clinical pharmacists and nurse practitioner.
- The practice provided a wide range of appointment types, including a daily walk in service, to improve choice and accessibility for patients. The daily walk-in service was used by patients across all the population groups and the practice were the only provider of GP services in the Clinical Commissioning Group (CCG) to offer this.
- Urgent and pre-bookable telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. The practice had successfully bid for a grant to expand and update the premises in 2016 to provide five more consultation rooms and a conference room.
- The practice made reasonable adjustments when patients found it hard to access services. The premises were fully accessible to those with restricted mobility and the practice had accessible parking spaces and a wheelchair for patients to use if necessary.
- For patients with visual impairments, door signs were also in braille.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- A practice newsletter was produced quarterly which promoted the range of services offered at the practice such as a carers event, a back pain event, flu immunisations and the walk-in service and it raised awareness of community services within the borough and CCG area.

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 nurses also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.
- The service were able to access a Holistic Assessment and Rapid Investigation Service for complex patients for Merton CCG.
- The practice provided medical services to a local care home with 35 residents. A business case was submitted by the practice to the CCG to undertake a proactive care home ward round pilot as the care home had the highest number of ambulance conveyances to accident and emergency (A&E) in the borough. The six month pilot project provided an enhanced level of primary care input into the care home and measured its impact on conveyances to local emergency departments by London Ambulance Service (LAS). Weekly ward rounds commenced from December 2017. Continuity of care was provided as the proactive care home ward round

Are services responsive to people's needs?

was always undertaken by one of two dedicated GP partners. The care home was provided with the bypass telephone line to ensure patients received timely care and the GPs worked closely with the local CCG medicines management pharmacist who undertook polypharmacy reviews. Data from the CCG compared with the previous year showed that after the pilot, the care home had dropped from the first to the fifth highest ambulance conveyor, the number of ambulance conveyances had reduced from 46 in 2017 to 12 in 2018 after the pilot which was a 74% reduction in LAS use by the home. As a result of this pilot, the scheme is in the process of being rolled out CCG wide.

- As a result of the pilot proactive care home ward round for a local care home, patient feedback from 15 patients demonstrated that:
  - 100% of those surveyed found the service useful and would recommend the service.
  - 100% rated the care home service as excellent.

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 teams to discuss and manage the needs of patients with complex medical issues.
- Double appointments were offered for specific services such as insulin initiation.
- The practice directly employed a clinical pharmacist who had undertaken training and was conducting reviews for diabetic patients. This was in response to the practice identifying that improvements were required for monitoring practice patients with diabetes.
- The practice employed a phlebotomist to enable blood testing appointments to be booked at the practice.

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 practice offered specific children's appointment slots in the morning and the afternoon.
- Appointments were offered from 7.30am on weekdays which suited those with school-age children.
- The practice offered dual GP six to eight week checks for both mothers and babies for convenience.
- Long-acting reversible contraception services (LARC) were offered at the practice and a sexual health clinic was on-site.
- A chlamydia screening service was provided for those aged 16-24.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, appointments were offered from 7.30am on weekdays and until 8pm on Tuesdays, which suited those of working age.
- Additional appointments were available during evenings and weekends in the extended access GP hub which was co-located in the practice.
- The practice actively promoted online services and used social media to promote practice events and community services.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, those with a learning disability and those affected by Female Genital Mutilation (FGM). Those identified as severely frail undergoing case management were also on the vulnerable adult register. The practice employed a specific care co-ordinator to maintain the practice registers.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Those identified as vulnerable, including carers, were provided with timely access to care and treatment via a practice bypass telephone number.

Are services responsive to people's needs?

- There was a dedicated learning disabilities lead GP who ensured that all 27 patients on the learning disability register had received an annual health check.
- Double appointments were regularly utilised for patients who were vulnerable.
- Systems were in place for interpreting services.
- Chaperone services were available including both male and female chaperones.
- The practice had systems to support carers including nominated carers' leads, a carers' event in July 2018 and a carers' leaflet developed by the practice.
- The practice had put themselves forward to be involved in a local Clinical Commissioning Group (CCG) pilot model of Social Prescribing aimed to connect medical care with local voluntary and community resources. Ahead of the project, one of the partners had volunteered to develop the social prescribing model for Merton CCG. Social prescribing appointments were delivered by a Social Prescribing Coordinator (SPC) two days per week, with each appointment lasting an hour. One of the partners oversaw the social prescribing project for the practice and had close links with the SPC. In the 12 month pilot period between the 1st of February 2017 to 31st January 2018, 316 patients were referred to the East Merton Social Prescribing programme, 250 of whom were from the Wide Way Surgery. Across the first three months of the project, 138 patients visited the two practices for social prescribing appointments (approximately 104 patients from Wide Way Surgery). The pilot saw a significant increase in health and wellbeing for patients using a health and well-being measure as well as significant decreases in both number of GP appointments (by 543) and A&E attendances (by 29 visits) in patients referred to the service. Patients and staff interviewed reported better self-management as a result of visiting the SPC. Additionally, interviewees attributed the success of the pilot to the drive and expertise of the GP lead and SPC. From April 2018 the social prescribing programme was rolled out across nine GP practices in the East Merton locality. The practice was filmed via the Healthy London Partnership as an example of social prescribing in London. (The Health London Partnership is an NHS organisation designed to collaborate with health and care stakeholders in London to improve health and well-being.) Social prescribing was promoted by the practice via the use of social media.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients were signposted to local psychological therapy services, a local dementia hub and crisis cafes through GP referrals and social prescribing.
- There was evidence that GPs provided weekly telephone consultations for patients with mental health needs who were awaiting input from mental health services.

Timely access to care and treatment

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 for same day and pre-bookable appointments and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised according to clear protocols for reception and clinical staff.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results were above local and national averages for questions relating to telephone access, opening hours, experience of making an appointment and ability to get an appointment. However, the practice told us that unverified published data in 2017 from the national GP patient survey indicated satisfaction with waiting times was below average. They had carried out a practice survey and an additional audit of waiting times and found that the delays were limited to the walk-in service. The practice produced an action plan in response to their findings to improve resources available and to improve efficiency of the service.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

Outstanding ☆

Are services responsive to people's needs?

- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice as outstanding for providing well-led services.

The practice was rated as outstanding for well-led because:

- A £1 million premises redevelopment had been completed in 2018, to provide space for collaborative working and care closer to home. The practice had been involved in years of planning and stakeholder engagement. The practice partially funded the development in conjunction with funding from the premises owner and securing funding from the NHS England London Improvement Grant Fund via a successful bid.
- The practice had initiated and led the creation of the first collaborative working Primary Care Home site in South West London.
- The practice developed and drove a considerable number of initiatives and projects both in the practice and externally in the Primary Care Home and Clinical Commissioning Group to ensure services met the needs of the local population.
- The practice provided innovative services to support staff and foster a positive culture.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them both internally and across the locality. For example, the practice wrote and successfully submitted a funding bid for the premises redevelopment, with a vision to provide space for collaborative working and care closer to home.
- 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.
- The practice had led the creation of the first Primary Care Home site in South West London for collaborative working between practices.
- Leaders and managers engaged with external stakeholders and influenced change in the CCG by initiating proposals and providing leadership for GP at scale projects. The GP partners and managing partner had developed and initiated a number of projects which were piloted in the Primary Care Home (PCH) GP collaborative and then adopted by the CCG or GP Federation. The majority of these projects were to address health inequalities and population needs in the locality.

Vision and strategy

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

- The practice aspired to be flagship practice for the Clinical Commissioning Group (CCG). There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- 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 care priorities across the region. The practice planned its services to meet the needs of the practice population.
- There were projects and plans to support development of practice services and quality of services across the locality.
- 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 challenged 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 and managers prioritised investment in staff including apprenticeships which were offered in conjunction with third-party organisations.

Outstanding ☆

Are services well-led?

- There were 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.
- The practice promoted learning and development for staff within the Primary Care Home (PCH) network and CCG. The practice had arranged for training across practices and shared learning with other practices and other CCGs.
- There was a strong emphasis on the safety and well-being of all staff and measures were in place to promote this which staff felt benefited them including a daily coffee 'debrief' session, chair yoga sessions, staff awards and a well-being package which was provided by the practice in response to staff feedback.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. There was an inclusive culture and an 'open door' policy with managers and leaders for all staff.

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 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 policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The practice intranet system which had been sourced and adapted by the managing partner, included an organisational 'dashboard' to allow continuous and effective monitoring across a range of systems.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints. Each incident was assigned to a partner to oversee.
- A range of quality improvement measures including 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 initiated projects to address key areas where issues were identified from performance data and had implemented action plans. They had experienced common themes contributing to areas of lower performance in 2016/17 including an unstable and reduced practice nursing team and a considerable increase in patient list size. Quality improvement projects included addressing lower uptake for cervical screening and childhood immunisations and diabetes performance indicators.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

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 and to ensure patients received care and treatment in a timely way.
- The practice submitted data or notifications to external organisations as required.

Outstanding ☆

Are services well-led?

- 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.
- In additional to annual staff surveys, the practice had led a staff engagement event for staff from all four PCH practices to discuss the benefits of primary care at scale and to gather initial staff feedback about collaborative working.
- There was an active patient participation group. The PPG had influenced a number of changes and been involved with running events over the past year.
- The practice initiated a collaborative PPG meeting for PPGs from the four Primary Care Home (PCH) practices. The meeting was used to gather patients views on positives and negatives of collaborating.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice used social media to cascade information to the public.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation both internally and externally in the locality and Clinical Commissioning Group (CCG).

- There was a strong focus on continuous learning and improvement.
- 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 were clear about areas where improved was required based on performance and risk information in conjunction with analysis of the local population needs. A range of procedural audits, clinical audits and other quality improvement projects had been developed.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The lead GP and managing partner had key roles within the Clinical Commissioning Group (CCG) locality, GP Federation and the GP collaborative Primary Care Home. There was evidence the provider developed, drove and initiated projects both in the practice and externally to impact change in services to meet needs of the local population. Innovations and projects included: the social prescribing model, an approach to improved diabetes care, the care home project, standardised protocols and 'intelligent' electronic templates for the patient record system, the NHS clinical pharmacist programme for the CCG, staff support and retention systems, the premises redevelopment, educational workshops for CCG practices on ensuring quality and safety of care and the GP at scale project on behalf of the GP Federation.
- The practice promoted learning and development for staff within the Primary Care Home (PCH) network and CCG. The practice had arranged for training across practices and shared learning from initiatives and projects with other practices and other CCGs.

Please refer to the evidence tables for further information.