Barlby Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Barlby Surgery on 15 July 2015 Overall the practice is rated as outstanding.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example they had teamed up with a local charity to deliver a range of health projects in the local community.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they met people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the GP appointments during the day. The practice provided Skype consultations twice weekly, offering approximately 12 consultations per week and there was a GP who was based at the reception desk who provided both telephone consultations and a triage service. The practice was open from 8.00am to 9pm Mondays to Friday and 9am to 5pm on Saturday and Sundays
- The practice had formed a partnership with a local charity to provide a multi-stranded approach to work on health access to primary care services for BME people for whom English was not a first language. The practice had co-produced a short film with patients, clinicians and faith groups called **"**Talking from the heart" exploring mental health diagnosis and therapy by combining medical and faith advice
- The practice had "Practice Champions" which was a project aimed at parents and children and young people aged 16-21. The Practice Champions supported other patients through education, signposting and peer support. This had increased the amount of young people who attended the surgery for both general information and specific concerns.
- The chief executive sent all staff a weekly 'staff matters' bulletin by email. This provided them with any information about the practice including staffing matters, training opportunities, and any changes within the practice group.
- They had developed two training packages. One for clinicians, which entailed fortnightly consultant-led training for GPs via webinars in a collaborative learning environment designed to enhance clinical knowledge and delivering excellent patient services and another for receptionists training as Healthcare Assistants (HCAs). The training was used by other local practices.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. . A slot for significant events was on the weekly clinical meetings and monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

Good

The practice is rated good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice had developed clinical protocols so that the links to NICE and other bodies were embedded in clinical practice. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had acted on suggestions for improvements and changed the way it delivered services in response to feedback

Summary of findings

from patients and staff. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

We found the involvement of other organisations and the local community is integral to how services were planned and ensures that services meet people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs The practice was part of the whole systems integrated care (WSIC) project for people with multiple and complex needs. They ran WSIC clinics which were attended by GPs, hospital consultants, district nurses and social services care coordinators.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding 

The practice is rated as outstanding for being well-led. It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. Leaders have an inspiring shared purpose and strive to deliver and motivate staff to succeed. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG) which influenced practice development.

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

Outstanding 

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

An Age UK support worker attended the practice two days a week to support older patients and their carers to access timely care and community support. The practice was part of the whole systems integrated care (WSIC) project and ran WSIC clinics for over 75s. They had achieved and implemented the gold standards framework for end of life care.

People with long term conditions

Outstanding 

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had formed a partnership with a local charity to provide a joint approach to work on health access to primary care services for Black and minority ethnic (BME) people for whom English was not a first language. Services provided included a programme of in-depth mentoring provided from within the practice, helping patients to access primary care services by accompanying patients to GP appointments and providing advice on self-management of conditions. The practice also took part in a programme of Community Health Workshops on a range of chronic conditions.

Families, children and young people

Outstanding 

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all

standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice ran monthly mother and baby Paediatric Hub Clinic in partnership with consultant paediatricians from the local hospital. We were told the clinic had proved successful in reducing the number of referrals to secondary care and has allowed patients to see a consultant quickly within the community.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice offered working aged patients access to extended appointments and was open seven days a week. They offered on-line services which included appointment management, messaging clinicians, viewing patient records, repeat prescriptions and registration. They also provided Skype consultations twice weekly, providing approximately 12 consultations per week

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people 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. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). 94% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice participated in Mental Health Ward rounds of the psychiatric wards based in the same building We saw data that evidenced transfers to A&E were reduced from 4 per week to 0.4 per week over a nine month period as a result of this. They had also co-produced a short film with patients, clinicians and faith groups called **"**Talking from the heart" exploring mental health diagnosis and therapy by combining medical and faith advice.

Summary of findings

What people who use the service say

We spoke with 24 patients during our inspection and received 22 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Patients said the care was good and staff were friendly, professional and accommodating and that all staff treated them with dignity and respect.

Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care. The national GP patient survey found that 89% of respondents described their overall experience of the practice as good and 70% said that they would recommend the practice to someone new.

Areas for improvement

Outstanding practice

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Barlby Surgery

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, a practice nurse, an expert by experience and a CQC observer.

Background to Barlby Surgery

Barlby Surgery provides GP primary care services to approximately 9,200 people living in Westminster. The practice is staffed by five salaried GPs, three male and two female who work a combination of full and part time hours. The practice is a training practice and employs two trainee GPs and one trainee nurse. Other staff include a nurse, two practice managers and six administrative staff. The practice holds a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 8.00am to 9pm Mondays to Friday and 9am to 5pm on Saturday and Sundays, which was particularly useful to patients with work commitments. The reception telephones were staffed from 8.00am to 9pm Mondays to Fridays and 9am – 5pm weekends. Appointment slots were available throughout the opening hours. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provided a wide range of services including clinics for asthma, chronic obstructive pulmonary disease (COPD), contraception and child health care. The practice also provided health promotion services including a flu vaccination programme and cervical screening

The practice is located in the north of the borough of Kensington and Chelsea. The local population is characterised by a large proportion of young working age residents and is ethnically diverse as a result of high levels of migration in and out the borough. The proportion from Black and Minority ethnic groups is twice that found in the rest of the borough. Although residents have the highest life expectancy in the country there are significant pockets of poor health in the more deprived areas.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Detailed findings

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

- Older people
- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 15 July 2015. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. Administrative staff and receptionists were encouraged to log any significant event or incident and we saw there were two templates, one for administrative incidents and one for clinical incidents. Staff we spoke with were aware of their responsibilities to bring them to the attention of the practice manager. These were usually discussed on the day they occurred. Action points were then circulated immediately to all staff. For example, we saw that there had been an incident which caused a delay in getting blood test results, the practice had reviewed their processes and implemented a new double check system to ensure the correct labels and corresponding forms were sent along with the blood samples.

We saw evidence to confirm that the practice completed a significant event analysis (SEA) annually which included identifying any themes and learning. We saw that the learning was shared across all the five GP practices run by the company and with West London CCG.

National patient safety alerts were disseminated by the practice manager to the relevant practice staff by email through the practices computer system messaging facility. Staff we spoke with told us of recent alerts they had discussed regarding the increase in the harm from synthetic cannabis.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. All staff had received relevant role specific training on safeguarding adults and children. Staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located in intranet pages and displayed on the walls in reception and treatment rooms. Monthly child safeguarding meetings were held at the practice, which was attended by health visitors, school nurses, consultant paediatricians and GPs from the practice. The GPs attended all external safeguarding meetings.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role. The practice nurse provided chaperone training to the administrative staff members. All staff we spoke with understood their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff providing these duties had been Disclosure and Barring Service checked.
- The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction. This was accessible on all computer desktops for all staff. There was a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment testing (PAT) had been carried out in July 2014. A schedule of testing was in place. We saw

evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out at the same time.

- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. Monthly infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Medicines were stored in medicine refrigerators in the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings, for example the prescribing of antibiotics. The practice took part in monthly benchmarking meetings with other local GP practices, which periodically was attended by the CCG's Medicine Management Team who report on prescribing levels at each practice.
- Recruitment checks were carried out and the seven files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- The operations manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. They had developed a workforce analysis spreadsheet which informed their staffing levels based on patient numbers. We saw that where they had an increase in patient numbers, both clinical and non-clinical staff numbers had also been increased. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The reception manager occasionally provided cover in reception during busy periods.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and child masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw the practice had direct computer links to NICE and other guidelines and clinicians told us they found this much more practical and allowed clinicians to access up to date evidence based care. The practice also developed clinical protocol links to these guidelines and referral pathways. We saw the practice had monthly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records carried out by the clinical director.

Management, monitoring and improving outcomes for people

All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation are proactively pursued. High performance is recognised by credible external bodies as they . had been awarded the Quality Practice Award (QPA) from the Royal College of General Practitioners (RCGP).

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 100% of the total number of points available, with 5.1% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. The QOF data showed:

- Performance for diabetes related indicators was 100% which was 13.6% above the CCG and 9.9% above national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100% which was 12.8% above the CCG average and 11.6 above national average.
- The dementia diagnosis rate was 100%, which was 9.5% above the CCG and 6.6% above the national averages.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We saw audits had been carried out by both trainees and salaried GPs. There had been seven clinical audits completed in the last two years, all of these were completed audits where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, one GP had audited the effectiveness of Omeprazole when prescribed at low doses, for patients with gastro intestinal diseases. The GPs were concerned that low doses had no proven benefit but still had the potential to cause harm. They referred to the NICE clinical knowledge summary which stated that patients should not be treated with this medication on a long-term basis. On first audit there were 404 patients prescribed some form of this medication. Action taken by the practice included contacting patients currently receiving this medication by telephone to discuss their omeprazole prescriptions and to invite them in for physical health checks and reviews. The GP facilitated an educational session with other practices in their group about evidence for omeprazole dosing. The practice reviewed all patients using this medication and showed us data to confirm that after re-audit they found there was a decrease in the amount of patient's receiving omeprazole prescriptions to 334.

The practice also carried out monthly audits on anti-biotic prescribing and referrals to ENT, Ophthalmology and neurology. We saw that individual GPs performance in these areas were compared and discussed. Data showed that the practice was meeting and exceeding the targets set by the CCG in these areas.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also

Good

Are services effective?

(for example, treatment is effective)

checked that all routine health checks were completed for long-term conditions such as COPD and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary. The evidence we saw confirmed that all clinicians had a good understanding of best treatment for each patient's needs.

The team made use of clinical audit tools and clinical meetings to improve performance. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved at their weekly clinical meetings. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also attended a monthly benchmarking group run by the CCG. Performance data from the practice was evaluated and compared to similar surgeries in the area.

Effective staffing

The practice staff team included medical, nursing, managerial and administrators. Staff had the skills, knowledge and experience to deliver effective care and treatment. We reviewed staff training records and saw that all staff had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety. Staff also had to complete regular mandatory courses such as annual basic life support and defibrillator training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example, reception staff told us they had received information technology, conflict resolution and customer service training.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support, for example we saw all GPs have an annual appraisal with the clinical director where they reviewed consultations, referrals, prescribing and career aspirations. All staff had an appraisal within the last 12 months, had monthly one-to-one meetings and had access to coaching and mentoring. GPs told us they were supported to achieve their revalidation.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw they were participating in the Whole Systems Integrated Care (WSIC) pilot and as such worked closely with integrated care teams coordinated by the CCG. These teams combined all aspects of health and social care and included GP's, social services and local charities, such as Age Concern. GPs told us this had improved communication and sharing of relevant information and had reduced duplication and confusion for patients, carers and staff. All patients had care plans which they had been involved in drafting. They included information about how to manage their conditions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Good

Are services effective?

(for example, treatment is effective)

The practice manager carried out ad hoc audits to assess the completeness of these records and that action had been taken to address any shortcomings identified, for example where care plans had not been updated following reviews.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this. The practice also documented in patients notes if they had refused a chaperone when offered.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Patients were then signposted to the relevant service. A care coordinator was available at the practice two days a week and smoking cessation advice was available from a local support group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 82% and the national average of 82%. The practice sent text message reminders for patients and would follow up patients who did not attend for cervical screening. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were better than the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 84% to 97% and five year olds from 92% to 97%. Flu vaccination rates for the over 65s were 76%, and at risk groups 59% which were above the CCG and national averages.

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

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, meningitis in children, flu and measles. There was also information about local health and community.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 22 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We also spoke with two members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and the practices internal patient survey. The evidence from both these sources showed patients were satisfied with their experience at the practice. The practice was average or above for its satisfaction scores on consultations with doctors and nurses. For example:

- 87% said the GP was good at listening to them which was similar to the both the CCG and national average of 88%.
- 82% said the GP gave them enough time which was similar to the both the CCG and national average of 84%
- 92% said they had confidence and trust in the last GP they saw which was similar to the both the CCG and national average of 93%.
- 81% said the last GP they spoke to was good at treating them with care and concern which was similar to the both the CCG and national average of 85%.
- 86% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 88%.
- 89% patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice good in this area. For example, data from the national GP patient survey from 2014 showed 72% of practice respondents said the GP involved them in care decisions compared to 80% for the CCG and 81% nationally. The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received from all GPs. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete a carer's form where appropriate and there was written information available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

There was a system of support for bereaved patients both provided by the practice and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. People were given the option to be referred for bereavement counselling or signposted to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Deaths of patients were discussed at the weekly clinical and monthly practice meetings.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised.

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health. The local population was diverse with a high number of people for whom English was a second language and little knowledge of health care provisions. The practice had formed a partnership with a local charity to provide a multi-stranded approach to work on health access to primary care services for BME people for whom English was not a first language. Services provided included a programme of in-depth mentoring provided from within the practice, helping patients to access primary care services by accompanying patients to GP appointments, outreach visits and providing advice on self-management of conditions. The practice also took part in a programme of Community Health workshops on a range of chronic conditions such as diabetes.

Eight workshops were delivered with 129 attendees, 119 - 1 hour mentoring sessions took place with 43 patients and 128 hours of outreach visits took place to 59 patients. This approach to health access work reached more people with chronic conditions before they became serious urgent conditions and helped to reduce non-attendance at the practice and hospital admissions. Language support in accessing and understanding health services and conditions was also provided to patients across all services, in Arabic and Somali.

Patients over 75 years had a named GP to co-ordinate their care. The practice was part of the whole systems integrated care (WSIC) project and ran WSIC clinics for over 75s which were attended by GPs, district nurses and social services care coordinators. They had a list of older people who were housebound, whom they would visit regularly, particularly frail older patients. A Primary Care Navigator was based at the practice two days a week, to support older patients and their carers to access timely care and community support. Their role included befriending, attending patients' homes, liaising with social services and acting as advocates. GPs carried out weekly ward round visits to residents of a local care home to look after their physical and mental health and wellbeing. GPs told us that have reduced unnecessary hospital admissions, GP appointments and residential placements through timely intervention and care co-ordination.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed.

The practice ran monthly mother and baby monthly Paediatric Hub Clinic in partnership with consultant paediatricians from the local hospital. We were told us the clinic had proved successful in reducing the number of referrals to secondary care and had allowed patients to see a consultant quickly within the community. GPs told us they liaised regularly with health visitors who also attended some Multi-Disciplinary Team Meetings. The practice offered appointments on the day for all children under 5 when their parent requested the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening.

The practice had "Practice Champions" which was a project aimed at parents and children and young people aged 16-21. The Practice Champions supported other patients through education, signposting and peer support. The practice staff told us they were a vital link between the practice and local communities by assisting with public health campaigns and preventative measures, such as immunisation, screening and sexual health.

The GPs told us that patients whose circumstances may make them vulnerable such as the homeless or people with learning disabilities were coded on appropriate

registers. They worked within a multi-disciplinary team that met monthly to plan the care and management of vulnerable patients. They offered homeless people and travellers residing in the area health checks and provided medical reports or letters of support where necessary. They had a shared care arrangement for substance misuse patients with the local provider and provided onsite substance misuse counselling. They also participated in the Learning Disability DES to ensure that their patients were given care plans that met their needs.

The practice offered working age patients access to extended appointments and was open seven days a week. They offered on-line services which included appointment management, messaging clinicians, viewing patient records, repeat prescriptions and registration. They also provided Skype consultations twice weekly where approximately 12 consultations per week took place. We saw consent was recorded on patient notes. The practice also allowed out of area registrations for patients who moved away (university/work) to remain on their list, which enabled patient choice and continuity of care. Additionally people who worked in the area but lived elsewhere could also register with the practice.

The practice had a register of patients experiencing poor mental health. These patients were invited to attend annual physical health checks and 94% had been reviewed in the past year.

They took part in the shared care DES and had quarterly meetings to discuss these patients and address any concerns. Patients also had access to an onsite counsellor.

The practice participated in Mental Health Ward rounds of the psychiatric wards based in the same building. GPs told us it was a local initiative to enable early identification of physical health deterioration and prevent onward referral to secondary care for mental health inpatients. They said this had had a positive impact on the number of patients being referred unnecessarily to A&E and had given them continuity of care. We saw data that evidenced transfers to A&E were reduced from 4 per week to 0.4 per week over a nine month period.

The practice had teamed up with a social enterprise to tackle immediate health and social issues affecting Muslim communities such as mental health. They had co-produced a short film with patients, clinicians and faith groups called "Talking from the heart" exploring mental health diagnosis and therapy by combining medical and faith advice.

The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. Some treatment and consultation rooms were on the first and second floors, which were accessible via a lift. Accessible toilet facilities were available for all patients attending the practice.

We were told by staff that a high proportion of the practice population did not speak English as their first language therefore the practice used a telephone translation service, had access to interpreters and their website could change into a range of languages including Somalian and Arabic.

Access to the service

People can access appointments and services in a way and at a time that suits them. The practice was open from 8.00am to 9pm Mondays to Friday and 9am to 5pm on Saturday and Sundays, which was particularly useful to patients with work commitments. The telephones were staffed from 8.00am to 9pm Mondays to Fridays and 9am – 5pm weekends. Appointment slots were available throughout the opening hours. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The practice also had a frontline GP who was based at the reception desk who provided both telephone consultations and a triage service. The practice said this provided expert care at the point of contact. This had reduced the need for patients to have an appointment with a GP.

Feedback from the national GP survey published in 2014 was positive about the appointment system. For example;

- 85% of respondents described their experience of making an appointment as good compared to the CCG average of 79% and national average of 74%.
- 94% were satisfied with the surgery's opening hours. compared to the CCG average of 80% and national average of 75%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment stating they could always get an appointment when needed.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. All verbal complaints were recorded on a spreadsheet. The practice managers handled all complaints in the practice. We saw that these were analysed on a monthly basis and the outcome and actions were sent to all members of staff.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last 12 months and found these were dealt with in a timely way, in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, a patient had complained about not getting their repeat medication due to needing a review. We saw that the practice had explained to the patient why medication reviews were necessary, but had come to an agreement with the patient as to the frequency of that review.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Details of the vision and practice values were part of the practice's annual business plan and on their website and displayed throughout the practice. The practice vision and values was to provide world class accessible healthcare through innovative solutions and being responsive to patients needs by investing in staff through structured coaching, leadership and training.
- We spoke with eight members of staff and they all knew and understood the vision and values.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. Clinical staff were line managed by a clinical director and non-clinical staff were line managed by an operations director. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff had to read the key policies such as safeguarding, health and safety and infection control as part of their induction. All seven policies and procedures we looked at had been reviewed annually and were up to date.

The practice held monthly board meetings and bi-weekly directors and senior managers meetings which were attended by all senior staff and practice managers. We looked at minutes from these meetings and found that performance, quality, training and accounts had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above national standards. They had scored 1000 out of 1000 in 2013 and 899 out of 900 in 2014, which was 11% above the CCG average and 6% above England average. The clinical director was the lead for the different areas of the QOF and we saw an action plan had been produced to maintain or improve outcomes. We saw QOF data was regularly reviewed and discussed at the practices monthly meetings.

The practice took part in a peer reviewing system with neighbouring GP practices in Kensington and Chelsea. We looked at notes and saw that they met quarterly and discussed topics such as A&E attendances, referral pathways and inappropriate referrals to secondary care. It was also an opportunity for practices to work together to develop services focused on the needs of the local population for example residential care.

There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements. We found robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records. We saw that a patient's risk matrix was regularly discussed at practice meetings and updated in a timely way.

Leadership, openness and transparency

The directors of the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The directors were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. They encouraged a culture of openness and honesty.

We saw from minutes that practice meetings were held monthly. . Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They felt they worked well together and that they were a highly functional team which listened and learnt, and were aware of their areas for improvement, such as the need to reduce unplanned A&E attendances.

We also noted that team away days were held every year. Staff said they felt respected, valued and supported, particularly by the directors in the practice. All staff were involved in discussions about how to run and develop the practice, and the directors encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Outstanding ☆

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

The practice managers were responsible for human resource policies and procedures. We reviewed a number of policies, for example, the recruitment and qualification checking procedure. We were shown the staff handbook which was available to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

We found the leadership promoted a culture of learning and quality improvement and saw clear evidence of integrated care at the practice. For example, working with the Age UK care coordinator and diabetes mentors from the local community.

The chief executive sent all staff a weekly 'staff matters' bulletin by email. This provided them with any information about the practice including staffing matters, training opportunities, and any changes within the practice. For example, one issue we looked at gave details of a NICE guidelines update for type 2 diabetes and Immunisation against meningococcal B disease for infants. It also contained information about a tri-borough substance awareness training programme , which had been developed from both a drug treatment and cultural awareness perspective.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met quarterly and was attended by the practice Director of Patient Engagement, involvement and community participation. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team. For example, we saw that where they had asked the practice to increase daily GP consultations the practice implemented a GP led telephone triage system.

The practice had also gathered feedback from staff through staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of a number of local pilot schemes to improve outcomes for patients in the area. For example, they had teamed up with a local charity to deliver a range of health projects in the local community.

They were also a training practice both for GPs and nurses. At the time of our inspection they employed two trainee GPs and one trainee nurse. They had developed two training packages, one for clinicians, which entailed fortnightly consultant-led training for GPs via webinars in a collaborative learning environment, which were designed to enhance clinical knowledge and delivering excellent patient services. The other training package was for receptionists training as Healthcare Assistants (HCAs).

The practice had been awarded the Quality Practice Award (QPA) from the Royal College of General Practitioners (RCGP) which recognises practice teams who have demonstrated both clinical and organisational Excellent Practice in the delivery of primary care. They were also awarded the Investors In People award.