Amersham Vale Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Amersham Vale Practice on 24 June 2015. Overall the practice is rated as outstanding.

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

- The practice had robust safeguarding processes in place and effective systems to ensure at risk children were monitored, for example, frequent child attendees in accident and emergency (A&E).
- The practice used innovative and proactive methods to improve patient outcomes.
- The practice worked with local organisations to support vulnerable patients, including a homeless shelter and took part in a local project to support patients with severe mental illness.
- The practice had a range of registers to monitor the most at risk and vulnerable patients including those at risk of unplanned admissions to hospital.
- 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 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.
- A range of appointment options were available, and the practice had increased appointment length to 13-15 minutes for all patients.
- 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).
- The practice had a clear vision which all staff were aware of. Staff felt supported and motivated by the management team and felt happy to make any suggestions or raise concerns.

Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was evidence of actions and learning from incidents that occurred, however the practice did not have an incident reporting policy.
- Some risks were assessed and managed including infection control, however the practice did not have assurances that regular health and safety and fire risk assessments for the premises were carried out by the buildings management company, and whether any risks had been identified.

We saw several areas of outstanding practice including:

- Safeguarding processes for the practice were embedded in practice culture and all staff had a clear understanding of their roles and responsibilities. The practice had a child protection clinical and administrative lead and there was evidence of regular links externally with the clinical commissioning group (CCG) safeguarding meetings as well as discussion in weekly clinical meetings.
- The practice demonstrated improved patient outcomes in a range of population groups, for example, increased point of care testing for HIV, contributing to HIV guidelines to manage HIV in primary care; improved chlamydia screening rates and improved uptake of cervical screening and subsequent treatment following a study where HPV self-swabs were implemented.
- The practice had set a higher target to achieve than the national QOF target, in line with best practice, to ensure they were monitoring more patients with the potential for uncontrolled diabetes and they had improved the patient pathway for diabetes care.
- The practice had increased the flexibility of access to appointments for vulnerable patients who were unable to utilise the standard appointment and telephone system, by implementing a register of those patients in the practice and prioritising them for appointments. Patients on this register were seen within an hour of attending the practice, or received an urgent call back.
- The practice worked closely with a local homeless shelter to provide general medical care. These patients were able to access traditional primary care through the practice, including nursing care and vaccinations.
- The practice had a very active patient participation group (PPG) and had implemented an administrative PPG lead to work directly to improve patient and practice communications. The PPG meetings included external speakers and themed PPG meetings.

However, there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Obtain assurances that health and safety risk assessments for the premises, including buildings assessments and fire risk assessments have been completed and whether any risks have been identified.
- Improve the incident reporting process to include reporting of near misses and non-clinical incidents as well as significant clinical events and ensure an incident reporting policy is in place.
- Update infection control policies, to ensure policies include those for sharps, spillages and management of bodily fluids and control of substances hazardous to health (COSHH).
- Ensure that all practice procedures are documented and are available for staff to refer to where necessary, including temporary staff and trainee GPs.

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 to report incidents. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Most risks to patients were assessed and well managed.

Are services effective?

Outstanding

The practice is rated as outstanding 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. 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 average or above for most aspects of care. Feedback from patients about their care and treatment from clinical and non-clinical staff was consistently and strongly positive. We observed a patient-centred culture. Staff offered kind and compassionate care and worked to overcome obstacles to achieving this.

We found positive examples to demonstrate how patient's choices and preferences were valued and acted on and how patients were emotionally supported to cope with their illness. The practice also offered emotional support for those families that had suffered a bereavement.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations, particularly those deemed as most at risk. It acted on suggestions

Summary of findings

for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice regularly reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG).

The practice had refined the appointment system, providing a range of appointments and booking methods to improve access to appointments. Patients told us they could get an appointment with their named GP, there was continuity of care and urgent appointments available on the same day, however there were some difficulties with getting through on the telephone, which the practice was actively reviewing and had changed as a result of complaints. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and development strategy. Staff understood the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the partners and practice manager. Staff had received inductions, regular performance reviews and attended staff meetings and events.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk, although not all risks were assured. The practice proactively sought feedback from patients, through satisfaction surveys and the patient participation group (PPG) and acted on feedback.

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, for example 100% of patients over 75 with fragility fractures were treated with an appropriate bone sparing medicine.

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 avoiding unplanned admissions. It was responsive to the needs of older people, and offered rapid access appointments for those with enhanced needs. The practice ensured that all patients who were housebound were placed on the avoiding unplanned admissions register so that they had collaborative agreed care plans and were closely monitored. Housebound patients were provided with access to urgent and routine home visits.

People with long term conditions

Outstanding 

The practice is rated as outstanding for the care of people with long-term conditions. Nationally reported data showed that outcomes for patients were consistently high, for example for patients with diabetes. The practice had improved the patient pathway for diabetes management so there was a team approach and a focus on holistic patient care. Nursing staff and GPs worked with patients to ensure jointly agreed care plans with patient-centred goals. Diabetes care included strategies to promote motivation and self-management. Patients with long-term conditions who were at risk were placed on the practice's avoiding unplanned admissions register. The most complex and at risk patients including those with end of life care needs were discussed at weekly practice meetings, in addition to the three monthly palliative care meetings, to ensure patients were closely monitored.

The practice had offered home visits and rapid access appointments for those with enhanced needs. The practice ensured that all patients who were housebound were placed on the avoiding unplanned admissions register so that they had collaborative agreed care plans and access to appointments within one hour where needed. The practice provided annual reviews for those with long-term conditions and they could access longer appointments and dedicated pre-bookable appointments.

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Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were robust 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 accident and emergency (A&E) attendances. GPs reviewed all communications from A&E regarding childhood attendances so that any themes or patterns were flagged. There were clear and frequent communication lines between the practice safeguarding children's lead and the health visiting team and flagged children were discussed at weekly clinical meetings as well as during six weekly child protection meetings.

Immunisation rates were 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. The practice was responsive to the needs of children and prioritised children under 12 for appointments. GPs specialised in the treatment of young adults, including areas such as chlamydia and HPV screening. The practice had promoted a range of sexual health screening options in the practice.

Working age people (including those recently retired and students)

Good

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

The practice was proactive in offering online services for appointments and prescriptions and utilising technology to improve accessibility for this population group, such as text message reminders, cancellations and results. The practice provided a virtual patient participation group option for those who were unable to attend the meetings, in order to capture the views of this population group. The practice offered a range of health promotion services including cervical screening, bowel and breast cancer screening and smoking cessation. The practice had offered smoking cessation services to 92% of eligible patients in 2014/15.

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

Summary of findings

registers of patients living in vulnerable circumstances including homeless people, travellers, adults at risk, children at risk, carers and those with a learning disability. It offered longer appointments for people with a learning disability, often booking a number of appointments to ensure time for assessments to be completed.

The practice had a register for those most at risk of unplanned admissions and completed collaborative care plans to support patients in the community. These patients were discussed at the weekly practice meetings and any admissions to hospital were followed up by GPs. Those patients on the unplanned admissions register were prioritised for appointments within an hour. Housebound patients were automatically entered onto the avoiding unplanned admissions register to ensure close monitoring of this patient group.

The practice closely monitored vulnerable children. A nominated child safeguarding administrative lead and clinical lead attended all child protection meetings. 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.

The practice recognised the need to provide extra support for marginalised groups and maintained close links with a local homeless unit. The practice were recently commissioned to provide the drugs and alcohol hub for the clinical commissioning group (CCG), improving accessibility for practice patients. The practice provided a flexible and innovative approach to those deemed vulnerable by circumstance who were unable to manage the usual booking system, such as frequent non-attenders, homeless patients and those with limited mental capacity. The practice placed these patients on their "green list" so that if patients telephoned or presented at the practice, they would be prioritised for appointments and seen within an hour. All staff throughout the practice were aware of this system.

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). Ninety three per cent of people experiencing poor mental health had received an annual physical health check. The practice had a higher than national and local incidence of mental illness. The practice worked in a multidisciplinary team to support those with the most enduring mental health problems, which included

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meetings every four months with a psychiatrist. The practice also looked after adults at a specialised unit with enduring mental illness; the practice provided a co-ordinated visit to maximise flu vaccination uptake in this client group.

Those deemed most at risk were placed on the avoiding unplanned admissions register and had collaborative care plans. Those with the most severe problems were placed on the practice's "green list", to ensure flexibility and support with accessing medical care at the practice.

The practice was signed up to the dementia enhanced service and had improved their dementia diagnosis rate by 26% within six months from 2014-2015, being the second highest achiever in the clinical commissioning group (CCG). The practice had provided dementia training for clinical and non-clinical staff to improve awareness.

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What people who use the service say

We spoke with 10 patients including patient participation group (PPG) members and reviewed 20 CQC comments cards during our inspection. We looked at results from the national GP patient survey undertaken in 2014 and published in 2015. We also looked at the results of the NHS Friends and Family Test (FFT) data from December 2014 to June 2015.

We found that patients were very positive about their experiences at the practice. Patients we spoke with were satisfied with the care and treatment they received, and felt that they were treated with respect and involved in their care. From reviewing CQC comments cards, 100% were positive about their experiences at the practice with regards to care received, and where there were some negative comments, this was due to the appointment system. NHS FFT data showed that over the last seven months, on average 92% of patients would recommend the practice.

GP patient survey data showed that the practice were at average or above for the local clinical commissioning group (CCG) for satisfaction with consultations with GPs:

- 91% of patients would recommend the practice, which was above local CCG average of 77% and national average of 78%.
- 90% of patients described the overall experience at the practice as good compared to CCG average of 83% and national average of 85%.
- 91% said the last appointment they got was convenient compared with CCG average of 90% and national average of 92%.
- 81% of patients were satisfied with the opening hours compared to CCG average of 75% and national average of 76%.
- 79% of patients were able to get an appointment to see or speak to someone the last time they tried compared with CCG average of 82% and national average of 85%.

We spoke with two PPG members on the day and they did not identify any concerns with the practice. They shared many positive examples of how the practice provided responsive and good quality care. The PPG had been very active in the practice and the practice had carried out action plans in response to areas of improvement identified by the PPG. This included improving the telephone system.

Amersham Vale Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP Specialist Advisor, a Practice Manager Specialist Advisor and an Expert By Experience. The Specialist Advisors and Expert By Experience were granted the same authority to enter Amersham Vale Practice as the CQC inspector.

Background to Amersham Vale Practice

Amersham Vale Practice provides primary medical services in Lewisham to approximately 8300 patients and is one of 44 practices in Lewisham clinical commissioning group (CCG). The practice population is in the third most deprived decile in England.

The practice population has a higher than national and CCG average representation of income deprived children and older people. The practice has a large proportion of patients registered of working age; 77% are aged 17-64. The practice has a lower than average number of patients over 65 at 7.7% compared with national average of 16.7% and a higher number of children aged 0-4 at 8% compared with the national average of 6%. Of patients registered with the practice, 31% are White British, 26% are from mixed ethnic groups and 15% of Black African origin.

The practice team at Amersham Vale is made up of four GP partners, with a fifth GP applying to be a partner at the time of inspection, two salaried GPs and three trainee GPs. The practice team also consists of three practice nurses, a part time locum health care assistant, a practice manager, three administrative staff members and six reception staff members. The practice is currently an active training practice for trainee GPs and provides teaching to medical students.

The practice operates under a Personal Medical Services (PMS) contract, and is signed up to a number of enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice is open from 8am to 6.30pm Monday, Tuesday and Friday; from 8am to 8pm Wednesday and Thursday and on Saturdays from 9am to 11am. The practice has opted out of providing out-of-hours (OOH) services to their own patients and directs patients to the out-of-hours provider. The practice also benefits from sharing the health centre premises with a GP-led walk-in centre open between 8am-8pm, where they can direct patients if required.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out an announced comprehensive inspection on 24 June 2015. During our visit we spoke with a range of

Detailed findings

staff including five GPs, a trainee GP, a practice nurse, the practice manager and five reception and administration staff. We spoke with eight patients who used the service and two members of the practice's Patient Participation Group (PPG). We reviewed CQC comment cards completed by 20 patients sharing their views and experiences of the service. We looked at a number of medical records.

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We received information from Lewisham clinical commissioning group and NHS England.

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

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

We also looked at how well services 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
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Safety alerts were cascaded via email and we saw the alerts stored on the practice's shared drive so they were accessible to staff. Alerts were discussed in clinical meetings where indicated. We were told about a recent alert that was sent in relation to faulty blood glucose monitoring machines.

The practice had a system in place for reporting incidents and significant events and all staff were aware of this, however the practice did not have an incident reporting or a significant event policy in place. The staff we spoke with knew to report incidents to the practice manager. Staff used an accident book to record staff accidents and we saw this was utilised. Non-clinical incidents were not routinely recorded using incident forms; however clinicians frequently used a standardised template to record clinical incidents and clinical significant events. We reviewed a folder on the practice's shared computer drive, which showed a number of clinical significant events and minutes from meetings where they were discussed.

Learning and improvement from safety incidents

Clinical significant events were discussed at weekly clinical meetings if indicated and the practice also held specific significant events meetings with clearly recorded events and reflections on what went well and what could have been improved. For example, the practice had identified that there were delays for a patient for scans which may have contributed to delayed diagnosis and an admission to hospital that could have been avoided. As a result of the incident the practice educated clinicians that the weekly clinical meeting discussions need to be widened to include any complex cases for peer learning and support. The practice also shared the incident with the local hospital in relation to delays in the patient getting timely scans, and we were shown letters confirming this.

We saw that although non-clinical incidents were not formally recorded, there were examples of non-clinical incidents that stemmed from verbal complaints being discussed in practice meetings with administrative and reception staff. There was clear evidence that the learning and actions had been cascaded to staff and systems were altered.

Reliable safety systems and processes including safeguarding

The practice had robust systems to manage and review risks to vulnerable children, young people and adults. There were nominated adult safeguarding and children's safeguarding GPs and they had received relevant training to support them to carry out these roles. Training records showed that all staff had received relevant role specific training on safeguarding children, with clinical staff receiving training to level 3. All staff had received in-house adult safeguarding training from the adult safeguarding lead GP. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

There were safeguarding adults and child protection policies and all staff we spoke with were familiar with these. There were also safeguarding contact numbers available in clinical rooms and administrative areas of the practice for staff to refer to. All staff we spoke with were aware of the policies, the safeguarding lead GPs and how to flag a concern outside of the practice. The practice had also appointed an administrative lead for safeguarding children, to support the work of the GP lead.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, flagged vulnerable children and housebound patients.

There was a chaperone policy, which was visible in the waiting room, in consulting rooms and on the practice shared drive. The chaperone policy was also available on the practice website for patients. All nursing staff had been trained to be a chaperone. Reception and administrative staff would act as a chaperone if nursing staff were not available. Those that chaperoned had also undertaken chaperone training and understood their responsibilities, including where to stand to be able to observe the examination. All non-clinical staff undertaking chaperone duties had Disclosure and Barring Service (DBS) checks.

Medicines management

Good

Are services safe?

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medicines audits were carried out with the support of the local clinical commissioning group (CCG) pharmacy teams to ensure the practice was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about infection control. An external cleaning company was employed to carry out cleaning for the whole health centre premises. We saw cleaning schedules in place for the practice including a cleaning and checking schedule for clinical areas. The practice did not have documentation or assurances in place from the cleaning company or management of the premises for information relating to the control of substances hazardous to health (COSHH). There was no COSHH policy for the practice.

An updated infection control policy and supporting procedures were available for staff to refer to. There was also guidance in the practice for action in the event of a needle stick injury and spillages of bodily fluids. Staff were aware of the procedures to follow, however there was no specific policy documented for the management of sharps or dealing with bodily fluids. There was evidence of Hepatitis B status for all staff. Notices about hand hygiene techniques were displayed by all sinks. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received internal training about infection control specific to their role and received annual updates. We saw evidence that the lead practice nurse had carried out infection control audits internally, the latest in May 2015, however no actions had been identified.

The health centre management company had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) and the practice had a copy of this. The last assessment was carried out in March 2013.

Equipment

All equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was June 2014. Updated testing was due shortly after inspection and we saw emails confirming this had been booked. The fixed electrical wiring check was arranged by the management company for the premises and we saw the practice had obtained the policy from management company stating five yearly checks were to be completed, but it was unclear when the last check was carried out.

We saw evidence of calibration of relevant equipment; for example weighing scales, nebulisers, blood pressure measuring devices and refrigerator thermometers in April 2015. Fire extinguishers had been checked in 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This was supplemented by an NHS employer's identity check policy. Records we looked at contained evidence 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. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The practice also completed a training needs analysis for new staff, ensured staff signed a confidentiality agreement and completed an induction checklist.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff we spoke with confirmed that reception staffing was well-managed and there had been no instances where there was lack of staffing to be able to carry out their role safely. Administrative staff were able to support reception

Good

Are services safe?

where needed, to maintain safe levels of staffing. An administrative staff member planned clinical staff rotas and trainee rotas in advance. It was practice policy that when the clinical commissioning group (CCG) offered protected learning time the practice did not close and only two GPs were scheduled to be off at one time.

The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements and the practice had actively ensured they had more than adequate GP resource and had not needed to recruit locums for more than 12 months. We were told that they were awaiting a health care assistant to commence employment and practice nursing sessions were currently limited, however GP sessions also included some nursing slots to support the practice nurses, for example with vaccinations.

Monitoring safety and responding to risk

The practice had some assurances, systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, however as the GP practice was located inside a purpose-built health centre, health and safety checks, premises risk assessments and fire risk assessments were arranged by the management company. We were told that the practice had tried to communicate with the management company to obtain the information they needed, however there were difficulties maintaining communication links with them. The practice did not have processes in place or alternative measures to provide assurance that these risks had been adequately assessed. The practice did complete regular and thorough checks for equipment, medicines, fire extinguishers, and staffing. Health and safety information was displayed for staff to see. We saw that the practice's liability insurance was up to date.

The practice did not have written policies relating to deteriorating and acutely unwell patients, however staff were familiar with patients that were to be prioritised for appointments, such as children. Staff were aware of using the practice's panic button system and a privacy screen, and emergency scenarios had been discussed during life support training. It was standard practice to ensure there were always at least two staff manning reception.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available in the practice including access to oxygen and access to an automated external defibrillator (used in cardiac emergencies) was via the walk in centre located on the same floor as the practice. When we asked members of staff, they all knew the location of this equipment and records confirmed that emergency oxygen was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Monthly checks were in place to ensure that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan that was in date and accessible for staff on the practice noticeboard as well as the shared drive. The practice had put in place actions in the event of a fire, flood, loss of computer systems and Ebola emergency. There was a buddying system with a local GP practice in the event of some of these emergencies.

The practice did not have a fire risk assessment. We were told this was because the management company arranged the fire risk assessment for the health centre, and arranged fire drills, however the practice was not always informed when these would occur. The last fire drill was in February 2015. Records showed that all staff were up to date with fire training.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

From reviewing medical records, care plans and from discussions with clinicians, the practice demonstrated how NICE guidance for diabetes, dementia and chronic obstructive pulmonary disease (COPD) were followed. Staff described how they carried out comprehensive assessments to identify holistic needs of patients. They explained how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes received annual reviews but some reviews were completed every six months where diabetes required careful monitoring, and we saw evidence of this in patient records.

We were shown the person-centred, joint care planning template the practice used for diabetes patients as part of a local enhanced service. There was evidence of individualised goals, patient engagement and referrals onto other services where required. Staff could demonstrate that they had a thorough understanding of a physical and psychological needs assessment in patients with long-term conditions such as with diabetes and programmes of care incorporated motivational educational sessions to empower patients to meet their goals. Feedback from patients confirmed they felt the diabetes care provided was of a high standard. Eighty eight per cent of diabetic patients had received an annual review in 2014/15. The practice had identified GP leads in specialist clinical areas such as end of life care, diabetes, heart disease and asthma and the practice nurses supported this work. One of the practice nurses had a special interest in diabetes and COPD and another practice nurse supported GPs with end of life care.

The practice was signed up to the national avoiding unplanned admissions enhanced service and also a locally agreed enhanced service which focussed specifically on the over 65s. The practice used computerised tools to identify patients who were at high risk of admission to hospital and automatically ensured housebound patients were on this register, so that this specific groups of vulnerable patients could have their needs met. Patients on this register had annual or six monthly reviews of their collaborative care plans, which we were shown, and a named GP acted as a co-ordinator for their care. We saw that after these patients were discharged from hospital they were followed up by a GP to ensure that all their needs were continuing to be met. Emergency hospital admission rates for the practice were relatively low at 10% compared to the national average of 14%.

The practice was signed up to the enhanced service for dementia diagnosis and support. Patients with dementia received annual reviews and all patients who were due an annual review in 2014/15 had received one. The practice promoted dementia reviews opportunistically, unless they were identified as at risk patients on the unplanned admissions register, where they received a collaborative care plan. The practice supported patients with mental health needs and reported they had a higher than national and clinical commissioning group (CCG) average incidence of patients with severe and enduring mental health needs, as 1.38% of the practice population were on the mental health register for the practice. The practice had completed 106 annual reviews, which was 93% of patients on the register for 2014/15. The practice discussed patients with severe mental illness with a consultant psychiatrist three times yearly, and we saw minutes of these meetings where best interest decisions were applied where appropriate.

The practice was signed up to the learning disability health check enhanced service, and completed or were part way through completion of 74% of annual reviews. The practice reported that they completed annual reviews in more than one stage of double appointments to ensure all health professionals were consulted where required and a thorough review was completed, and this gave the opportunity for carers to be incorporated into the health checks and care planning. We were shown an example of a patient with learning disabilities where a previously undiagnosed condition was picked up by the GP completing the health check and a referral was made to a specialist.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included coding and data input, scheduling and recalling clinical reviews, managing repeat prescriptions and monitoring accident and emergency (A&E) attendances. The information staff collected was used to monitor the service and improve outcomes of patients. Some of the information supported the practice to carry out clinical audits. Robust recall systems were in place for long-term conditions registers, with administrative staff sending out reminders to patients for annual reviews. When reviewing repeat prescription requests, administrative staff specifically checked if patients were due an annual review and prompted patients via a reminder on the prescription script.

We were shown the practice's shared drive with a number of clinical audits that had been undertaken over the last few years. We reviewed three completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The practice had completed a housebound patients audit as the result of a significant incident, with the aim to be proactive rather than reactive to needs of these patients. The initial audit identified that of the 38 patients who were housebound in 2013/14, 95% had received an annual review but no patients had care plans. The practice placed all housebound patients registered at the practice onto the admissions avoidance register so that this would highlight these patients as high risk. Following implementation of the collaborative care plan and annual reviews, the re-audit in 2014/15 showed that 90% had a care plan in place the following year. Additionally, 100% of the housebound patients had received a consultation compared to 95% in the first round. The intervention resulted in an improvement in the way housebound patients were coded, an increase in the number of patients recognised as housebound and an improvement in the frequency of contacts that the GP surgery had with its housebound population.

The practice had also undertaken a gout audit in 2013 and re-audited in 2014, measuring six criterion, which included ensuring that all those who had a diagnosis of gout and those on gout medication had specific annual blood tests taken, and that gout was diagnosed and coded correctly. The audit was a completed audit cycle with a slight improvement against the criteria set. The annual blood test for gout had improved from 24% to 34% for patients with a diagnosis of gout; there was an improvement from 41% to 53% for blood tests for those on specific gout medication and diagnosis of gout in clinical records improved from 93% to 100%. The practice planned to repeat the audit in 2015 and further improve GP education around management of gout in primary care.

The third completed audit cycle we were shown was where the practice had reviewed the uptake of seasonal flu vaccinations in patients with learning disabilities and autism. This audit was selected specifically to improve the practice's uptake of seasonal flu vaccinations for these patients where uptake was low. The initial audit was undertaken in January 2015. The practice found that the previous year, out of 79 patients with learning disabilities and autism, only 13% were immunised. Alerts for flu vaccinations were placed on patients' records and the results of the initial audit were cascaded to staff to improve awareness amongst clinicians. The practice also promoted uptake via making literature available in the waiting area and giving leaflets to patients and carers during consultations. The second audit was completed after three months, and showed an increased uptake of the vaccination to 22% for learning disability and autism patients for the 2014/15 winter period. The practice planned to repeat the audit again in the next flu season and promote uptake with written invitations.

We were shown an audit currently underway and previous projects in the practice to target and promote sexual health screening, which was reflective of the practice's population demographic. The clinical audit that was currently being undertaken was an audit of HIV testing, with the aim to commence routine HIV testing in line with the British HIV association guidance, 2008. Guidance states that where incidence of HIV is above 2 in 1000, practices should be offering HIV testing for all newly registering patients. The practice had identified that prevalence of HIV in Lewisham was significantly high at 7.9 per 1000 patients. The practice found that for a six week period from May 2014 to June 2014, one out of 351 patients who registered was offered

Outstanding ☆

Are services effective?

(for example, treatment is effective)

HIV testing compared to the same period in 2015, where 50 patients had been offered HIV testing. Furthermore, the practice had a significantly high turnover of patients registering and leaving the practice, so diagnosing patients at registration would appropriately assist in monitoring outcomes for the practice's transient population of patients. One of the lead GPs had contributed a chapter specifically on HIV and blood borne viruses, in a book related to working with vulnerable groups in primary care and the practice contributed to the publication of national primary care guidance for HIV where point of care testing for HIV is advocated.

We were told that other audits were linked to medicines management information. The practice took part in the CCG prescribing incentive scheme audits, for example we saw an audit relating to erectile dysfunction medicines.

The GPs monitored outcomes for patients using information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.) The practice reported a high turnover of patients; between 36% and 45% of the practice population per year due to their transient population. There were many examples of how the practice had put systems in place and tailored services to ensure the range of people's needs were met, so that their patients were monitored and provided with continuity of care as far as possible. Although the practice had a high turnover of patients, they had achieved a total QOF score of 97% for 2013/14 compared to CG average of 93% and national average of 94%. The practice had achieved a higher total QOF score of 99% for 2014/15. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was better or similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- Percentage of over 65s with a fragility fracture treated with bone sparing medication was 100% compared to national average of 81%.
- The practice's prescribing rates were better than national figures in relation to prescribing of antibiotics and hypnotic medication and similar to national average for prescribing of anti-inflammatories.

The practice had completed a project in 2012 to improve the standard and consistency of lifestyle and dietary advice given to patients with diabetes, and in particular to improve the management of patients identified as requiring weight management intervention. This was based on NICE guidance. Following this project, the practice piloted a diabetes programme in 2013/14 which focussed on patient-centred care planning and integrated team working. The practice undertook weekly clinical meetings to specifically to discuss patients with poorly controlled diabetes. The practice had set a higher target to achieve than the national QOF target, in line with best practice, to ensure they were monitoring more patients with the potential for uncontrolled diabetes. The practice had sustained improvements in the indicator for the diabetes blood test that shows how well diabetes is controlled from 47% in 2011/12 to 64% in 2013/14 and 61% in 2014/15, from implementation of the new approach to diabetes care, despite an increased prevalence of diabetes in the practice. This demonstrated that the practice had improved the pathway for diabetic patients.

The practice had followed best practice guidance for end of life care. It had a palliative care register and had regular weekly internal clinical meetings where patients were discussed as well as multidisciplinary meetings every three months with the palliative care nurse to discuss the care and support needs of patients and their families. End of life care patients were allocated a named GP to act as a case co-ordinator. From reviewing records we could see that advanced care planning discussions were being held, however specific care plans were not always utilised to record these discussions.

Those on the unplanned admissions register who had A&E attendances and emergency admissions were flagged up to the named GP. An audit was completed monthly to review A&E attendances and emergency admissions to identify patterns and potential commissioning ideas for the CCG. Any A&E attendances raising concerns about vulnerable children were flagged to the lead GP for safeguarding children.

The practice kept a number of other registers to identify other vulnerable groups, for example carers, those with

learning disability and homeless patients. In addition, they held a "green list" which contained any vulnerable patient where they had frequently not attended appointments or had difficulty accessing practice services. All staff were aware of this list and this ensured the practice could monitor patients who were at risk of not seeking medical care.

The practice took part in benchmarking data in comparison with other practices in the CCG and GP network by attending monthly meetings. Dementia diagnosis rate for 2013/14 was lower than expected at 0.32 compared to national average of 0.54. We were shown that the practice had signed up to the local enhanced service for improving dementia diagnosis, and had sustained a 26% improvement in diagnosis rate between September 2014 and March 2015, which was the second highest achieving practice in the CCG.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. The practice had ensured that clinical and non-clinical staff had received in-house dementia training to improve awareness and most staff had received mental capacity act training. We noted an extensive skill mix among the doctors with partners having portfolio careers. Two doctors had additional diplomas in sexual and reproductive medicine, one with a diploma in family planning, four with diplomas in women's health and obstetrics, two with diplomas in elderly medicine, two with post-graduate qualifications in tropical medicine and infectious diseases, and one GP having additional academic and lecturing roles. Two of the practice GPs had contributed to publications related to chlamydia screening and HIV testing in primary care and the practice manager had contributed to a book for GP training.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.)

The practice was a training practice for GP trainees, with one of the GPs being the programme director for the Lewisham GP training scheme. Trainee GPs had access to a senior GP throughout the day for support. We received highly positive feedback from the trainees we spoke with about the support provided by the practice, as trainees received a weekly protected learning session with a trainer and they attended weekly clinical meetings.

Practice nurses had a diverse skill mix, with additional qualifications including a psychology degree, a certificate in diabetes care and cancer care. All nurses had background experience in emergency medicine. One of the nurses was a nurse prescriber and one was the practice nurse advisor for the clinical commissioning group (CCG), supporting other practices in the locality. Nursing staff received yearly updates in administration of vaccines and cervical screening.

All staff undertook annual appraisals that identified learning needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example in diabetes and COPD.

Working with colleagues and other services

Out-of-hours reports, 111 reports and hospital letters were all inputted onto an electronic document system and were shared out between clinicians and dealt with daily. Any information requiring actions were allocated back to the administration team where appropriate. Clinicians maintained responsibility for coding any child accident and emergency (A&E) injuries to ensure a robust approach, whereby any trends that may be a cause for concern, such as multiple injuries, could be flagged up. Clinicians also followed up patients that had not attended hospital appointments, as identified from hospital letters, by calling patients personally or asking administrative staff to book the patients an appointment. The practice was had a similar process in place to follow up patients on the unplanned admissions register that were discharged from hospital.

Referrals were mainly made via an electronic referral system for routine referrals. GPs typed their own referral letters and these were processed by the administration team. Urgent two-week referrals were faxed and the practice obtained confirmation that the referral had been received. Test and scan results were seen and actioned by the GP that requested them, normally on the day they were

received. There were no abnormal or outstanding results that had not been dealt with on the day of inspection. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice clinicians worked closely with each other, with other health care professionals and local services. Weekly clinical meetings were held, with detailed minutes of the most at risk patients discussed. Clinical discussions included palliative patients, child protection concerns, those with care plans on the unplanned admissions register, those at risk with long-term conditions including diabetes and all newly registered housebound patients. District nursing and social services were able to attend these meetings and we saw minutes to confirm this. The practice held a meeting every three months with the palliative care team specifically to discuss those patients on the practice's palliative care register.

Six-weekly meetings were held between the GP lead for safeguarding children, the administrative lead for safeguarding children and a health visitor. Extensive minutes demonstrated that all families on the child protection register were discussed at each meeting and a note was also entered onto the electronic patient record for each patient. Any child protection concerns or flagged patients that were not on the register were included in these meetings. On-going verbal communications occurred between the administrative lead, GP lead and health visitor as the health visitors were based in the same building so concerns could be highlighted quickly where required.

The practice worked closely with a local project supporting patients with enduring mental health problems. This involved meetings three times a year with a psychiatric consultant to discuss each patient. The practice had close links with a local homeless shelter, providing GP services to these patients. The practice was recently commissioned to provide a drug and alcohol hub for patients in Lewisham CCG, where two practice GPs worked with a specialist nurse and drugs support workers via a team approach to improve holistic care for these patients.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to co-ordinate, document and manage patients' care. Administrative and clinical staff were trained to ensure practice activities were coded correctly and entered onto the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used several electronic systems to communicate with other providers. For example, there was an electronic referral system that allowed patient choice regarding location of their appointment, where routine referrals were sent electronically to a central hub. Results and letters were sent and received electronically or occasionally by post. Prescriptions were frequently sent electronically, where choice of pharmacy could be selected by patients.

The practice was signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.) The practice was in the process of subscribing to a local electronic system where patients' medical records could be accessed by accident and emergency and local authority staff such as social services, to ensure improved communications. This was advertised to patients on the practice website.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Patients with a learning disability, severe mental health issues and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.)

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

The practice did not routinely offer a health check to all new patients registering with the practice due to the high turnover of new registrants and leavers due to the transient population. Due to a higher than average incidence of HIV in Lewisham clinical commissioning group (CCG), the practice provided a medical questionnaire and offered all newly registering patients HIV screening. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice had increased uptake for chlamydia screening by offering testing opportunistically. A GP with a special interest in adolescent medicine involved the practice in a chlamydia screening programme for adults aged 15 to 24 years in 2012. Uptake increased from 3% in 2009/10 to 14% in 2010/11 and was maintained at 10% in 2014/15.

The practice provided stop smoking services for patients as well as signposting patients to a stop smoking group held in the health centre. For 2014/15, stop smoking services were offered to 92% of eligible patients. Only 6% of those referred took up the offer of smoking cessation, however of those that did, the quit rate was 48% for 2014/15, which was higher than the CCG average of 38%.

The practice was commissioned for a local drugs and alcohol hub in the practice for practice patients as well as taking referrals from other practices in the CCG. The practice vision was that by bringing the service from a central location into the practice hub, the resulting improved access would represent one less barrier to care. As the service had been operating for three months, there was limited information regarding success rates.

The practice's performance for cervical screening was 83%, which was in line with the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. In order to promote the importance of cervical screening, the practice took part in a HPV self-swab study from April 2014 to December 2014, aimed at women aged 29-64 who did not respond to their cervical smear invitation and were more than six months overdue. HPV self-swabs were offered opportunistically and those who tested positive were to book for cervical screening at the practice. Out of 176 patients invited, 145 accepted the self-swab, which was an uptake of 82%. Out of 133 samples returned, 86% were negative, however 14% tested positive and some of these required further investigations and treatment following cervical screening. This demonstrated improved outcomes and monitoring for those practice patients who had not initially attended cervical screening by targeted health promotion activities.

The practice encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. The practice had performed in line with the CCG average for the previous three years for breast cancer screening with an uptake of 62%.

The practice promoted health for homeless patients and had close links with a homeless shelter and charity. The practice also looked after adults at a specialised unit with enduring mental illness; patients were encouraged to attend the practice for their flu vaccinations and additionally, the practice provided a co-ordinated visit to maximise flu vaccination uptake in this client group. The practice had performed above average for flu vaccinations for patients over 65 years, achieving 70% in 2014/15 compared to the previous year of 67% and the CCG average of 66.5%. Flu vaccinations for at risk groups for 2014/15 was 57% and 56% for 2013/14 which was above national average of 53%. For 2014/15, the practice performed highly for providing flu vaccinations to patients with diabetes, achieving 94%, which was in line with the national average.

The practice offered a full range of immunisations for children as well as travel vaccines in line with current national guidance. Last year's performance was above average for the majority of immunisations. For example, all childhood immunisations for those aged 12 months were above or in line with CCG averages for 2013/14. Specifically

Outstanding ☆

Are services effective?

(for example, treatment is effective)

the five in one vaccination rate was 88% for 2013/14 and 2014/15 compared to CCG average of 87%. The pre-school booster achievement was 89% for 2014/15 compared with CCG average of 70%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent national GP patient survey from 2014, NHS Friends and Family Test (FFT) data from December 2014 to June 2015 and survey data carried out by the practice's patient participation group (PPG) in 2014. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the overall experience was rated as good by 90% of patients compared with the clinical commissioning group (CCG) average of 83%. The practice was rated 'among the best' as 91% of respondents reported they would recommend the practice, which was much higher than the CCG average at 77% and national average at 78%. The practice had positive responses for its satisfaction scores on consultations with doctors. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 87% and national average of 87%.
- 89% said the GP gave them enough time compared to the CCG average of 84% and national average of 85%.
- 92% said they had confidence and trust in the last GP they saw compared to the CCG average of 90% and national average of 92%

FFT data showed that on average 92% of patients would recommend the practice. The PPG survey data showed that 87% of patients felt they were treated with respect.

Patients completed 20 CQC comment cards to tell us what they thought about the practice and the overwhelming majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and all staff were empathetic and caring. They said staff treated them with dignity and respect. We also spoke with 10 patients on the day of our inspection which included families with children. All told us they were highly satisfied with the care provided by the practice. A number of patients commented that the service provided by the practice nursing team was extremely good. We also received only positive comments about the reception staff; patients felt they were patient and caring. Additionally, the national GP patient survey found that 93% said the receptionists at the practice were helpful compared to the CCG average of 89% and national average of 87%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The practice had a confidentiality policy in place and the practice had a process for ensuring staff had read this. The waiting area was large and seating was located away from the reception desk, but the practice also provided an area that patients could use if they wished to speak to a member of the reception team to ensure confidentiality could be maintained.

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 generally rated the practice well in these areas. For example:

- 77% said the last GP they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 81% and national average of 82%.
- 71% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 75%.
- 76% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 72% and national average of 77%.
- 73% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 62% and national average of 66%.

Patients we spoke with on the day of our inspection had very positive views; they told us that health issues were always discussed with them and they felt involved in decision making about the care and treatment they received, with particular comments from those that were supported by the practice, with long-term conditions. All

Good

Are services caring?

patient feedback on the comment cards was positive and aligned with these views, again with commendation from patients with long-term conditions such as diabetes. Patients told us they felt listened to by doctors and nurses and were able to make an informed decision about the choice of treatment they wished to receive. The practice viewed patients as individuals and active partners in their care. Practice staff showed us examples of joint care plans for patients with diabetes with evidence that realistic and meaningful patient goals had been agreed, barriers to achieving goals and how important the goals were for them were documented.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example 84% said the last GP they spoke to was good at treating them with care and concern compared to the clinical commissioning group (CCG) average of 82% and national average of 83%. The patients we spoke with on the day of our inspection and the comments cards we received were consistent with this survey information and reported that staff responded compassionately when they needed help and provided support when required. We saw a number of thank-you cards from patients and families over the last four years, particularly regarding the support that had been given following a period of significant illness.

The practice signposted patients to a counsellor and to bereavement services offered by the psychological therapies team. The doctors provided consultations following bereavement for family members and after each bereavement, families were sent a condolences card directly from the staff member who was the lead clinician for the patient, which also offered face to face appointments and provided signposting information for advice and support. We were given an example of how one staff member supported a patient emotionally due to severe anxieties around treatment. The practice ensured that the patient saw the same staff member for every appointment as a rapport had been built and they subsequently continued that support whilst the patient received counselling after they no longer needed regular appointments.

Information in the patient waiting room and the patient website also told patients how to access a number of support groups and organisations. The practice had a register of those acting as carers and the computer system alerted GPs if a patient was also a carer.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

A named GP in the practice regularly met with the Public Health team from the local authority and the clinical commissioning group (CCG) to share information about the needs of the practice. The clinicians then discussed this information during clinical meetings. It was evident that the needs of the practice population were clearly understood and systems were in place to address issues and identify needs in the way services were delivered. The practice reported a high turnover of between 36% and 45% of the practice patient list per year due to their transient population. Due to the high turnover, the practice had specifically tailored their services to ensure patients were closely monitored, to provide continuity of care to those with complex health needs. The practice also had a higher incidence of severe mental health patients than either local CCG or national average. There were many examples of how the practice had structured their services to ensure the range of people's needs were met.

For example, following a number of non-attendees for appointments, considering the transient population and the diversity of vulnerable groups in the local area, the practice had developed their own register of patients (the "green list") for patients unable to use the usual booking system. This register contained homeless patients, frequent non-attendees, and vulnerable children and adults. This ensured that any patient on the green list was provided with more flexibility with regards to accessing appointments and healthcare. All staff we spoke with were aware of this list and how it was used to meet the needs of patients. For example, the practice response to frequent non-attendees was to prioritise them for treatment if they phoned up or visited the surgery, enabling clinicians to opportunistically ensure they were receiving treatment and advice. Patients were seen within the hour that they visited the surgery. Patients with severe mental health needs who were on this list were also prioritised in the same way. The practice found that the "green list" reduced the number of non-attendees whist improving provision of care.

The practice had signed up to the avoiding unplanned admissions enhanced service. The practice ensured that all housebound patients were included on the admissions avoidance register with detailed care plans in place and a bypass contact number so that patients could get medical advice urgently.

The practice had changed appointment length so that all appointments offered to patients were 13 to 15 minutes to ensure patients had adequate time to meet their needs. The system for promoting health education and advice had been changed so that the clinicians provided the relevant information leaflets during each consultation rather than solely relying on patients to select information leaflets themselves. This was changed in response to the population turnover and the culturally diverse patient group.

The practice had an active and established patient participation group (PPG) that met quarterly and also had a number of virtual PPG members that were consulted via email and the online discussion forum. The practice also used the PPG meetings as education sessions and each PPG meeting had a theme with external speakers, for example the most recent one was related to travel health, in order to promote services locally and in the practice.

The practice and PPG had reviewed the appointments system and accessibility on many occasions, which resulted in a number of options for appointments as the system had been refined in response to surveys, complaints and feedback. The practice had also responded to complaints and survey information by employing an extra reception staff member specifically to improve telephone access in the mornings. The practice had established an administrative staff member as the PPG practice lead who worked closely with the PPG patient lead to review action plans from surveys and meetings and to improve patient and practice communication.

Tackling inequity and promoting equality

The practice had a culturally diverse population and a large proportion of patients spoke other languages. Staff spoke a range of languages, however the practice frequently relied on telephone translation services for patients. Double appointments were always offered for those requiring telephone translation. Information leaflets in other languages were available. The practice website was able to be viewed in a range of languages. One administrative staff member had received training from the practice to support

Are services responsive to people's needs?

(for example, to feedback?)

patients who were hard of hearing and there was a hearing loop installed in the practice. There was access to both female and male GPs. Patients could request to be seen or to speak to the GP of their choice.

Longer appointment times were also available for those with extra needs, for example learning disability patients were provided with triple appointments. The practice promoted health for homeless patients and had close links with a homeless shelter and charity, providing seasonal flu clinics for these patients. The practice were able to use the homeless charity address to register patients with no fixed abode. The local homeless shelter reported that the practice had been very supportive and a community nurse who visited the shelter weekly would make frequent contact with the practice to highlight any medical concerns. They told us the practice had also assisted the shelter with a hospital discharge detox programme for drug and alcohol users in 2014 where they visited patients at the shelter to provide medical services.

The "green list" for vulnerable patients assisted in tackling inequity and promoting equality for appointments and access to medical care. The practice also held registers for vulnerable adults and vulnerable children. There was a system for flagging vulnerability in individual patient records.

The access to the purpose-built premises had been designed to meet the needs of people with disabilities via a lift and accessible doors to the health centre. Once on the first floor, the practice was accessible to patients with mobility difficulties as patient facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access-enabled toilets and baby changing facilities. The waiting area was large and corridors were wide, with plenty of space for wheelchairs, prams and mobility scooters.

Access to the service

The practice was open from 8am to 6.30pm Monday, Tuesday and Friday; from 8am to 8pm Wednesday and Thursday and on Saturdays from 9am to 11am. The practice telephone lines were open from 8am-6pm Monday, Tuesday and Friday and from 8am-7pm Wednesday and Thursday. Appointments with GPs and practice nurses were available daily, with extended hours available with nursing staff on Wednesdays and with GPs on Thursdays.

The practice had provided a wide range of appointment options to improve accessibility for patients. They were able to provide a routine pre-bookable appointment within 48 hours of request with both GPs and nursing staff, and we saw during the inspection that appointments were available one day ahead. A window of time each morning was set aside specifically for the 48 hour pre-bookable sessions for patients to book in advance, to assist in reducing demand for same day appointments and to improve telephone access for patients. Pre-bookable appointments were also available to be booked up to six weeks in advance to assist patients with planning ahead for routine appointments, such as those with long-term conditions, which was changed as a result of patient participation group (PPG) surveys.

Every day the practice offered a large number of same day appointments for more urgent problems, available from 8am by attending the practice in person or telephoning. Emergency slots were also available each day in both the morning and afternoon surgeries. The practice prioritised certain vulnerable patient groups that were seen within the hour, including children under 12, pregnant women, patients listed as vulnerable on the practice register and those on the "green list".

The practice provided telephone consultations daily during routine GP surgeries with specific clinicians as well as with the duty clinician. Where telephone requests involved the priority groups of patients, these were marked as urgent. Patients most at risk who were on care plans received a one hour call back, this included patients at risk of unplanned admissions. Home visits were undertaken daily if required for urgent patients and routine home visits were also available for patients who were housebound.

Practice nursing services were available daily for smoking cessation, health checks, annual reviews and childhood immunisations, however due to limited practice nursing resource, additional nursing slots were allocated to all GPs for example for vaccinations.

Practice patients were able to access the GP-led walk-in centre within the same building between 8am-8pm if patients preferred this option. The practice had opted out of providing out-of-hours (OOH) services to their own patients and directed patients to the out-of-hours provider. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice worked to reduce non-attendees and operated a text message reminder system. This system was designed with the needs of the working-age population in mind as patients were able to cancel appointments via text message where needed. Appointments could also be booked and cancelled online by registering for online services. The practice website contained comprehensive information about the practice services, opening hours and information regarding health conditions, local services and what to do if the practice was closed. The website contained an easy to use section which linked to online services for appointments and repeat prescriptions.

The national GP patient survey information we reviewed for 2014 showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 81% were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 75% and national average of 76%.
- 73% described their experience of making an appointment as good compared to the CCG average of 70% and national average of 74%.
- 63% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 65%.
- 69% said they could get through easily to the surgery by phone compared to the CCG average of 65% and national average of 72%.
- 91% said the last appointment they got was convenient, compared to CCG average of 90% and national average of 92%.

From patients we spoke with and from reviewing CQC comments cards, the majority were satisfied with the appointments system and the appointments they got were convenient, but some reported some difficulty getting through on the telephone. PPG survey data also identified patients had difficulty getting appointments via the telephone system. Patients we spoke with confirmed that they could see a doctor on the same day if they felt their need was urgent.

The practice had carried out a telephone audit in response to patient concerns to identify areas for improvement. For June 2015, they found that out of 3168 calls, on average the wait was 1 minute 21 seconds. From this information, telephone audit data did not appear to directly correlate with patient frustrations reported on the day, however the practice still recognised that the telephone system needed to be refined.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website, in the practice leaflet and in a specific practice complaints leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at eight complaints received in the last 12 months and found that they were all acknowledged and responded to in line with practice policy and were dealt with in a timely way. Responses were open and transparent and the practice apologised where things had gone wrong.

The practice reviewed complaints during partners meetings and complaint themes and learning were discussed annually. We looked at the report for the last review and communications issues in relation to reception staff providing information to patients had been identified. Minutes of the administrative team meeting also showed these complaints had been shared with the reception and administrative team and improved communications to patients were encouraged such us updates with regards to waiting times.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found that details of the vision and practice values were part of the practice's business plan. The business plan was reviewed in 2013 and its strategy was to encourage steady growth of the practice. We were told the practice were due to update their business plan. Staff were able to articulate the practice's vision and values and one staff member reported that the practice had a pioneering and forward-thinking approach to patient care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies such as the practice results policy, safeguarding children, recruitment, infection control and confidentiality and all had been updated in 2015. We noted that some polices were concise and lacked detail, however we were told this was purposefully done, to ensure staff had access to the level of information they needed to carry out their roles. Updated policies were shared by email and nominated administrative staff took the lead to ensure staff had read the policies. The practice did not have documented policies for some procedures, although staff were aware of the correct process to follow; however this meant that information was not fully in place for new or temporary staff, such as GP trainees, to refer to.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, two GPs were information governance leads and there were GPs who led in safeguarding children and adults. We spoke with 13 members of staff during the inspection and they were all clear about their own roles and responsibilities and who to go to depending on the issue raised.

The practice identified, recorded and managed some risks such as infection control audits and the legionella risk assessment. The health centre management company was responsible for carrying out health and safety checks, premises risk assessments and fire risk assessments, however the practice did not have evidence or assurances that these had been completed and whether any risks had been identified. We were told that they had difficulty in obtaining information in relation to the premises from the management company.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example whistleblowing, sickness absence and bullying and harassment which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included all these policies. Staff we spoke with knew where to find these policies if required.

The practice held a range of meetings which were well structured, with evidence of thorough minutes for meetings. The practice held partners meetings monthly which involved the quality and outcomes framework (QOF), financial risks and governance discussions. (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.) Complaints and significant events were reviewed annually. Staff meetings involving the practice manager, administrative and reception staff were held monthly. Clinical meetings were held weekly for practice nurses and GPs and the practice nursing team also met weekly.

The partners and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using QOF to measure its performance. The QOF data for this practice showed it was performing in line and above national standards. We saw that there were nominated QOF leads and data was regularly discussed at clinical meetings and governance meetings.

The practice had an on-going programme of clinical audits which it used to monitor quality and to identify where action should be taken. Audits were frequently identified in response to QOF and the practice population profile to ensure services were effectively targeted. For example, the practice had carried out an HIV audit and a housebound patients audit. Evidence from other data from sources, including clinical commissioning group (CCG) meetings, the joint strategic needs assessment, incidents and complaints were used to identify areas where improvements could be made. The practice had commenced a project to improve diabetes care, as a result of lower QOF achievement for

Are services well-led?

Good

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

diabetes in previous years. HIV, chlamydia screening and an HPV self-swab study were implemented in the practice as a result of the transient practice population and high turnover of patients.

Leadership, openness and transparency

All staff told us that they enjoyed working at the practice and a number of nursing, administrative and reception staff had worked at the practice for a long time. Staff said they felt respected, valued and supported, and newer staff commented that they felt it was particularly well-organised. We noted that the GP partnership was stable as it consisted of some GPs that had worked at the practice for over 10 years. The partners and practice manager were always visible and staff, including bank staff, told us that they felt very well supported by the management team. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and appraisals and felt confident in doing so.

Communications with staff were frequently via emails and meetings. We saw from minutes that team meetings were held every month, however this was normally attended by non-clinical staff as GPs attended clinical meetings and partners meetings. We noted that team away days were held every 12 months with the next one planned for July 2015.

Seeking and acting on feedback from patients, public and staff

The practice actively encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG) meetings, surveys and complaints received. It had an active PPG of 61 members which included the virtual PPG. The PPG had carried out annual surveys and met every quarter. We were shown the last patient survey from 2014, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. As a result of the last PPG survey, the practice had appointed an additional reception staff member for the busy morning period, to reduce difficulty for patients in accessing the practice by telephone. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.)

Additionally, there were processes in place to review patient satisfaction via Friends and Family Testing (FFT) online and via paper format and the practice also provided the option for a children's FFT to capture the views of the younger population.

The practice had also gathered feedback opportunistically from staff through appraisals and staff meetings.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. Non-clinical staff had access to mental capacity act, dementia and customer care training.

The practice had supported 11 GP trainees to successfully complete training over the last 10 years and one of the GPs was the programme director for the local GP training programme. Trainees felt that the practice had offered them diverse learning opportunities and all GPs provided significant support.

The practice had a pioneering role in promoting education within primary care with staff demonstrating portfolio careers in education and research. Three staff members had contributed to publications in relation to HIV management, chlamydia screening and GP training, which promoted a learning culture in the practice. One of the GPs frequently shared learning inside and outside of the practice within their field of adolescent and sexual health, by presenting to local clinical commissioning groups (CCGs). One of the practice nurses was one of two practice nurse leads for the CCG and provided peer support to other practices.