St George's Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. The practice was previously inspected on 12 October 2016 and rated Good.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at St George's Medical Centre as part of our new methodology inspection programme.

At this inspection we found:

There was an open and honest culture in the practice which promoted a culture of learning and improvement. The practice had comprehensive systems in place and we saw evidence that these systems were improved upon through learning from incidents. Care and treatment was provided in line with evidence-based guidance and we saw many examples of the practice tailoring its service to improve the patient experience. Patients had positive views about the care they received and their interactions with practice staff. Access to the service was good and patients told us they could book routine and emergency appointments when needed. We saw many examples of continuous learning and improvement on the day of inspection.

For example:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.

Summary of findings

- The practice thought about patient experience and put services in place to improve such as providing in house phlebotomy services and acupuncture.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw three areas of outstanding practice:

- The practice had eight fully trained health champions that assist patients in the surgery and provide social and well-being events. For example, the health champions greet patients in reception and encourage patients to take advantage of the blood pressure monitoring pod in the patient reception area. The health champions provide a range of events for patients including weekly walks in the local park, chair yoga held at the practice and a gardening club. The champions also provide social services such as telephone support or accompanying patients to hospital appointments. The practice conducted a patient survey and we saw evidence that on average patients overall well-being (using a five point scale) went from a three to a five.
- The practice provide an alcohol counselling service in partnership with Westminster Drug Project. The service included one to one counselling with an alcohol counsellor, group sessions, medical interventions, detox opportunities (outpatient and inpatient) and inpatient rehabilitation. We saw evidence that there was a 60% success rate for patients who participate in the service.
- The practice provide an acupuncture service, free of charge, to all registered patients. The practice conducted an audit to identify whether patients felt this treatment had helped with their conditions. Patient were treated for conditions such as tennis elbow, neck pain, shoulder pain, lower back pain, knee pain and headache. During the audit the practice contacted patients who undertook this treatment between January 2017 and November 2017, 78% of patients felt this service had reduced their pain and would recommend this treatment.

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

- Improve the uptake of childhood immunisations.
- Improve the uptake of cervical screening in women between the ages of 25 and 64.

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

St George's Medical Centre

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 adviser and a practice nurse specialist adviser.

Background to St George's Medical Centre

St George's Medical Centre is a teaching practice located in Hendon, North London within the Barnet Clinical Commissioning Group. The practice address is 7 Sunningsfield Road, Hendon, London NW4 4QR. The practice provides a range of services including meningitis immunisation, alcohol cessation, childhood immunisations, extended hours access, dementia support, learning disabilities support, influenza and pneumococcal immunisations, rotavirus and shingles immunisation and unplanned admission avoidance. More information about services provided by the practice can be found on their website: www.stgeorgesmc.co.uk

The practice have a patient population of 10,300. At 50% the practice had a lower proportion of people with a long standing health conditions than the national average of 53%.The practice serves a diverse community. According to the most recent census data the most prevalent population groups included 38% White British and 14% Asian or Asian British. At 81 years, male life expectancy was above the national average of 79 years.

At 85 years, female life expectancy was above the national average of 83 years. The practice has fewer patients aged 60 years of age and older compared to an average GP practice in England. The percentage of patients between the ages of 20 and 44 is higher than the average GP practice in England. The surgery is based in an area with a deprivation score of seven out of ten (one being the most deprived). Older people registered with the practice have a higher level of income deprivation compared to the local and national averages. Patients at this practice have a much lower rate of unemployment when compared to the national average.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out DBS
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Clinical staff were trained to child safeguarding level 3; non-clinical staff were trained to child safeguarding level 1. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

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

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

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

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

Track record on safety

The practice had a good safety record.

Good

Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, we saw evidence of an incident where the safety of staff and patients was at risk, staff followed their training and managed to get the situation under control before the police arrived. Following the incident the practice installed personal safety alarms in every clinical consultation room, this was in addition to the panic alarm available on the practice clinical system.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice was not an outlier in respect of prescribing indicators.
- We saw no evidence of discrimination when making care and treatment decisions.
- Patients were able to access diagnostic tests at the practice including phlebotomy and spirometry.
- The practice provided anticoagulation clinics and sexual health clinics.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice provide longer appointments for older people, considered the needs of elderly patients and proactively provided home visits for older patients.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice provided in-house clinics for monitoring diabetes, asthma, chronic pulmonary obstructive disease (COPD) and coronary heart disease.
- The practice was not an outlier in respect of quality and outcomes indicators in 2016-17 relating to diabetes, hypertension and atrial fibrillation data. For example:
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 84% compared to the Clinical Commissioning Group (CCG) was 81% and the national average was 83%.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 89% compared to the CCG average 93% and the national average was 90%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the national target percentage of 90% or above. The practice were aware of this and practice nurse had a lead role in recalling patients to improve the uptake. The practice manager is overseeing the recall process.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 74%, which was below the 80% coverage target for the national screening programme. The practice were aware that uptake was below the national average. We saw evidence that staff at the practice wrote to patients three times to invite them for the screening programme.

Good

Are services effective?

(for example, treatment is effective)

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice provided annual health checks for patients with learning disabilities.
- The practice used alerts on the clinical system to identify vulnerable patients, and these patients were given appointments with regular clinicians only.

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

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 96%; CCG 92%; national 91%); and the percentage of patients experiencing poor mental health who have a record of blood pressure in the preceding 12 months (practice 95%; CCG 89%; national 90%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice was carrying out clinical audits:

- As part of national improvement initiatives, such as antimicrobial prescribing.
- To check it was following NICE guidelines, such as monitoring the weight and duration of patients on methylphenidate.
- To optimise the treatment and care it provides, for example patients with sickle cell disease. The practice conducted an audit to ensure that at risk patients receive the care they need to help prevent complications of sickle cell disease and timely reminders when vaccinations are due.

Audits were being repeated to see that improvement actions were being implemented and were effective. One example of a two-cycle audit looked to improve the identification and management of post-natal depression (PND). The first cycle audit showed that out of 244 deliveries, 32 women were identified with low mood/PND. Action was taken following this first cycle audit to increase screening for PND and the second cycle audit showed that over a 12 month period 109 women (92%) were assessed for PND out of 119 deliveries. The practice will continue to audit the screening and management of PND to ensure care delivered is in line with NICE guidance.

The 2016-17 Quality Outcome Framework (QOF) results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%.

The overall exception reporting rate in 2016-17 was 7.8% compared with a national average of 5.6%. None of the exception reporting rates for the clinical domains was significantly higher than the CCG or national averages. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

The practice was not an outlier for the following QOF indicators in 2016-17, performing above local and national averages. For example:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months was 74% compared to the CCG average of 69% and the national average of 72%.
- The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) was 100% compared to the CCG average of98% and the national average of 97%.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis was 85% compared to the CCG average and national average of 83%.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- The practice had weekly multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases that were referred using the urgent two week wait referral pathway was 60% which was above the CCG and national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 35 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 328 surveys were sent out and 93 were returned. This represented about 1% of the practice population. The practice was comparable to local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 88% of patients who responded said the GP gave them enough time; CCG 84%; national average 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG 94%; national average 95%.
- 87% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG 83%; national average 86%.
- 80% of patients who responded said the nurse was good at listening to them; (CCG) 88%; national average 91%.
- 88% of patients who responded said the nurse gave them enough time; CCG 90%; national average 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG 96%; national average 97%.
- 84% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG 88%; national average 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful; CCG 84%; national average 87%.

Involvement in decisions about care and treatment

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

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

The practice proactively identified patients who were carers through new patient registration forms and carer identification forms. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 196 patients as carers (roughly 2% of the practice list).

- The practice had eight health champions that provided assistance to carers. For example, a health champion accompanied an older carer to a hospital appointment

Good

Are services caring?

for the patient they had caring responsibilities for. The carer told the practice that without this assistance it would have not been possible to make the appointment.

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

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

- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.
- 86% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG 80%; national average 82%.
- 84% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG 88%; national average 90%.
- 75% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG 82%; national average 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments in its website, interpreting services and extended hours appointments five days per week.
- The practice improved services where possible in response to unmet needs. For example, it had a weekly phlebotomy service as well as all GPs and nurses provide phlebotomy services outside of the weekly clinic.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the practice secured funding to install automatic doors to the surgery, had a hearing loop in reception, the practice added two additional consultation rooms, and a patient pod was available in the reception area for height, weight, BMI and blood pressure checks.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice partnered with two local practices to employ a pharmacist as a shared resource.
- The practice had appointments that range from 5 to 30 minutes depending on the needs of the patient.

Older people:

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

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

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

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours nurse appointments Monday to Friday from 7.30am to 8.00am and extended GP appointments Tuesday to Friday from 6.30pm to 8.00pm.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- All vulnerable patients were flagged with an alert on the clinical system.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.
- Appointments could be booked up to six weeks in advance, one day in advance or on the day.
- Patients were not re-directed to walk-in centres as a rule, staff knew that they must inform the on call GP to arrange a same day appointment.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly above the local and national averages. This was supported by observations on the day of inspection and completed comment cards. A total of 328 surveys were sent out and 93 were returned. This represented about 1% of the practice population.

- 72% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 66% of patients who responded said they could get through easily to the practice by phone; CCG 67%; national average 71%.
- 88% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG 82%; national average 84%.
- 84% of patients who responded said their last appointment was convenient; CCG 77%; national average 81%.
- 81% of patients who responded described their experience of making an appointment as good; CCG 68%; national average 73%.
- 50% of patients who responded said they don't normally have to wait too long to be seen; CCG 53%; national average 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. There were 14 complaints received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, we reviewed a complaint regarding a cancelled appointment. The appointment was cancelled due to limited stock of item required for the appointment. The practice discussed the complaint and agreed to increase stock of this item to prevent this from happening again. The patient was formally notified and the practice apologised for the inconvenience.

Are services well-led?

Good

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

Our findings

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

Leadership capacity and capability

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

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

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

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

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, we saw that the practice had been open with a patient who felt a GPs behaviour was rude, the GP apologised and the complaint was discussed with staff to raise awareness of how their actions may be perceived. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a comprehensive meeting schedule in place to monitor the performance of the practice. For example, weekly multi-disciplinary team meetings, weekly clinical meetings, weekly practice meetings, weekly partners meeting, bi-monthly administration meetings, monthly nurse meetings and quarterly meetings with district nurses.

Managing risks, issues and performance

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

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

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group. The practice responded to PPG feedback. For example, the practice created a buggy parking area, added hold music to the telephone system, put hand sanitisers in the patient waiting area and created a monthly newsletter as a result of PPG feedback.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. For

Are services well-led?

Good

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

example, one of the GP partners at the practice was recognised for innovative thinking around transforming mental health services in the borough, supporting peers through a lunchtime walking group for GPs to 'walk and destress' and initiating a pilot across 15 GP practices to provide GPs with enhanced training skills for managing patients with medically unexplained symptoms.

- The practice had a noticeboard for staff dedicated to training, and leadership kept the board up to date with available training courses for any member of staff interested.
- The practice were developing plans to hold educational meetings for patients and carers and support groups for parents with young families.
- All of the GP partners had educational roles or roles focused on improving primary care in addition to their roles as GPs. For example, GP registrar trainer, medical student teaching, CCG clinical pathway development, RCGP Mental Health Clinical Fellow, personal and professional development tutors, FY2 doctor supervisor, GP facilitator and FY2 supervisors group and a CCG board member.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.