The Portland Road Practice

Quality Report

16 Portland Road
London
W11 4LA
Tel: 0207 727 7711
Website: www.portlandroadsurgery.nhs.uk/

Date of inspection visit: 25 March 2015
Date of publication: 20/08/2015

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

We carried out an announced comprehensive inspection at The Portland Road Practice on 25 March 2015. This was to follow up a comprehensive inspection we carried on 14 May 2014 where we found the practice was not meeting the essential standards of quality and safety in a number of areas. It was also to rate the quality and safety of the services under our rating scheme introduced in October 2014.

Overall the practice is rated as Good. Specifically, we found the practice to be good for providing, safe, effective, caring, responsive and well-led services. It was also good for providing services to the six population groups we looked at: 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; and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice had in most respects addressed concerns identified at our previous inspection and now complied with the essential standards of quality and safety that were not being met.
- The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice had several ways of identifying patients who needed additional support, and was pro-active in offering this.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

Summary of findings

- The practice had a clear ethos that put patients first and was committed to providing the best possible service to them.
- There was an open culture and staff felt supported in their roles.

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

The provider should:

- Ensure the records of safeguarding vulnerable adults training are available for all staff and, where necessary, all staff have completed up to date formal training in safeguarding of vulnerable adults.
- Ensure the keys to vaccination fridges are removed and securely stored when staff are not present in the rooms where they are located.
- Improve prescription security by ensuring they are not left in the printer overnight.
- Take further steps to address dissatisfaction raised by patients about continuity of care, access to appointments and waiting times.

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. The practice had an effective system in place for managing significant events, incidents and accidents and for communicating lessons learned to support improvement. There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The practice had appropriate safeguarding policies in place for both children and vulnerable adults. Staff had undergone recent safeguarding children training. We were told that staff had received also training in safeguarding of vulnerable adults but the records were not available to confirm the training undertaken. Arrangements were in place to ensure medicines were stored securely and were only accessible to authorised staff. However, the keys were left in one of the vaccine fridges and the room where the fridge was located was left unattended with the door open. Prescriptions were kept securely in most respects. However, we were told they were left in the printer overnight which could compromise security. There were appropriate infection control policies and procedures in place. The practice had appropriate processes for recruiting staff, including the required pre-employment checks. Risks to patients and staff were assessed and appropriately managed.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice scored positively in several areas of their QOF performance and where lower scores were achieved used QOF to steer practice activity. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. The practice participated in clinical audit and routinely collected information to review and improve patient care and outcomes. The practice worked in collaboration with other health and social care professionals to provide a multidisciplinary approach to their care and treatment. The practice had a consent protocol which staff were aware of and followed. There were appropriate arrangements in place to support staff appraisal, learning and professional development, although there were some gaps in evidence of training staff had received. The practice promoted good health and prevention.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the national GP patient survey showed the practice was rated broadly in line with the CCG average for dignity and respect, and involvement in decisions and support in their care and treatment. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect and involved them in decisions about their care and treatment. We observed during the inspection that staff treated patients with kindness and respect. The layout of reception and the acoustics of the building presented challenges in maintaining confidentiality but the practice was looking at ways to improve this. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the needs of its patients and was responsive to these. Data from the national GP patient survey showed the practice was rated broadly in line with average in the CCG area and nationally for convenience, experience of making an appointment and waiting times, and for being able to see or speak to their preferred GP. The views from patients we spoke with were mostly positive about access to the service, although some said it was difficult to get appointments that suited them. The practice had taken a number of steps to improve accessibility in the light of feedback, for example, the provision of walk-in clinics and the installation of a new telephone system. There was an effective complaints system. Staff we spoke with understood the complaints procedure and there was documentary evidence to confirm that lessons learned had been communicated throughout the practice, for example, at practice meetings. The premises and services had been adapted to meet the needs of people with disabilities.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service. The practice's mission was set out in practice leaflet and website and staff were committed to this. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice had a range of policies and procedures to govern activity which were regularly reviewed. There were named members of staff in lead roles and there was an open culture, where staff were clear about their own roles and responsibilities and felt supported in their work. There

Summary of findings

were arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Staff had received induction training and regular performance reviews. The practice sought feedback from staff and patients, including a patient participation group (PPG), which it acted on. The practice had a whistleblowing policy and all staff we spoke with were aware of the policy.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice held monthly multidisciplinary team meetings to discuss patients with complex needs including elderly and frail patients and those with end of life care needs. All patients aged over 75 had a named GP and were offered an annual health check. They also had care plans which were actively added to and amended as circumstances changed. For older patients and patients with long term conditions longer appointments home visits were available if required. Flu vaccinations were provided to older people in at-risk groups. The practice had a weekly carers support clinic run by a carers charitable group as well as the expert help of a Primary Care Navigator who was available to see all the practice's vulnerable groups to support their needs to live independently. Visits were made monthly to a local care home which involved a doctor attending ward rounds with a pharmacist, social worker and elderly care consultant. The practice took a pro-active approach to end of life care and also provided direct bereavement support, by calling patients in or by visiting them.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The needs of people with long term conditions were met by appropriately trained staff. Structured annual reviews were undertaken for patients with long term conditions, including diabetes, COPD, and heart failure. There were care plans in place for these patients. The practice liaised with other services to enable people with long term conditions to remain in their homes. The practice took part in regular clinical learning set (CLS) audits relating to long term conditions, for example diabetes and musculoskeletal conditions. The practice kept a register of patients identified as being at high risk of admission to hospital, including patients with long term conditions. Longer appointments and home visits, where needed, were available to patients with long term conditions. Flu vaccinations were provided to patients in at-risk groups, including those with long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided a weekly baby clinic on a drop-in basis run by a health visitor. Clinics were also run for child health care surveillance, contraceptive services, maternity medical services, immunisations and vaccinations. Expectant mothers and

babies had medical support from nurses and health visitors, delivered in conjunction with the practice. The practice provided a smear testing service and its performance for cervical smear uptake was 76%, which was just below the national average. There were procedures in place to safeguard children and young people from abuse. Both clinical and non-clinical staff had received child protection training in line with national guidance. There were regular meetings with health visitors and other health and social care professionals to review at risk children. In addition, the practice worked with the local tri-borough multi-agency safeguarding hub (MASH). The practice also participated in the local area 'Paediatric Hub' pilot to provide services and share expertise on the treatment of children.

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 practice was accessible to working people. For example, the practice provided a clinic from 6.30pm to 8.00pm on Monday and Thursday. Appointments could be booked on line and repeat prescriptions ordered electronically. A health check was offered to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. This included a free cardiovascular and diabetes risk assessment and advice on how to reduce the risk. Where appropriate patients were referred to a local exercise referral scheme, which provided supervised exercise sessions for people with a range of conditions. The practice ran a smoking cessation service and this included routine spirometry screening. Flu vaccinations were offered to patients aged 65 and older and the practice provided travel vaccinations and advice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice had recognised the needs of different groups in the planning of its services. Longer appointment times were available for patients with learning disabilities. There was access to an interpretation service for patients for whom English was not a first language. There was an e-mail service, for deaf patients. The practice had access to advocacy services available for patients, for example, to support and where necessary secure the consent of patients who lacked capacity. The practice kept a register of all patients with a learning disability and routinely recalled them to review and check their physical health and well-being. They were supported to make decisions through the use of care plans, which they were involved in agreeing. The practice had a weekly carers support clinic run by a

carers charitable group as well as the expert help of a Primary Care Navigator who was available to see all the practice's vulnerable groups to support their needs to live independently. The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with learning disabilities. Staff knew how to recognise signs of abuse and the process to follow in the event of any safeguarding concerns. However, the records were not available to confirm training received in safeguarding of vulnerable adults.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia). Staff responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Crisis referrals were made for acute mental health issues and the practice was able to facilitate same-day access to psychiatric support. Patients at significant risk were referred to the community mental health services. Patients with mental health problems (including those with dementia) were supported to make decisions through the use of care plans, which they were involved in agreeing. There were a range of protocols to support appropriate medicines management including recall procedures for patients with mental health conditions. The practice had an 'enduring mental illness' register and for many of these they worked in conjunction with the local mental health team and shared the responsibilities of prescribing. Longer appointments or home visits were arranged for this group of patients if required. The practice had links with the Kensington and Chelsea Community Assessment and Primary Service, a self-referral community drug and alcohol treatment and recovery service. There were also links to other local providers of drug and alcohol rehabilitation and recovery services, including those for homeless people and rough sleepers.

Summary of findings

What people who use the service say

We received 23 completed Care Quality Commission (CQC) comments cards providing feedback about the service. Patients commented on the caring doctors and the professional attitude of staff across the whole practice. Several said the practice offered an excellent service and the staff treated them with dignity and respect. Four patients commented on difficulties in getting an appointment, one was dissatisfied with the continuity of care and another the attitude of staff. We also spoke with ten patients on the day of our inspection, including two members of the Patient Participation Group (PPG). The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some patients' comments were less positive, including difficulty in getting to see their own GP and waiting time when they arrived for their appointment.

The practice's March 2015 NHS friends and family test showed 73% of patients would highly recommend the practice and 17% would likely recommend the practice to friends and family. An action plan was in place to broaden the scope of the survey and improve the scores further. In the national patient survey 2014/15 patient satisfaction was in line with CCG and national averages in response to questions about their involvement by doctors in planning and making decisions about their care and treatment. The responses to these questions regarding nurses were marginally below averages. The survey also showed patients were positive about the helpfulness of receptionists and the emotional support provided by the practice and rated it well in these areas. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, to improve access to appointments, a new telephone system and extra telephone lines were due to be installed in April 2015.

Areas for improvement

Action the service SHOULD take to improve

- Ensure the records of safeguarding vulnerable adults training are available for all staff and, where necessary, all staff have completed up to date formal training in safeguarding of vulnerable adults.
- Ensure the keys to vaccination fridges are removed and securely stored when staff are not present in the rooms where they are located.
- Improve prescription security by ensuring they are not left in the printer overnight.
- Take further steps to address dissatisfaction raised by patients about continuity of care, access to appointments and waiting times.

The Portland Road Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice specialist, and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP, practice specialist and expert by experience were granted the same authority to enter the practice as the CQC inspector.

Background to The Portland Road Practice

The Portland Road Practice is a single location surgery which provides a primary medical service through a Personal Medical Services (PMS) contract to approximately 7,500 patients in the Notting Hill, Kensington and Shepherds Bush areas of West London. The population groups served by the practice included a cross-section of socio-economic and ethnic groups. A high proportion of patients (13% of the practice population) were aged over 65. There were also above CCG and national average numbers of children cared for at the practice under the age of five (7.2% of the practice population) . At the time of our inspection, there were two GP partners and a practice manager partner at The Portland Road Practice. The practice also employed four salaried GPs, a practice nurse (covered by a locum nurse), a health care assistant and seven administrative staff.

The practice is registered to carry on the following regulated activities: Diagnostic and screening procedures; Maternity and midwifery services; Surgical procedures; and Treatment of disease, disorder or injury.

The surgery is open from 08:00 to 20:00 and Monday and Thursday; 08:00 to 18:30 Tuesday and Friday; and 08:00 to 13:30 Wednesday. Appointments are available from 08:30 to 20:00 Monday and Thursday; 08:00 to 18:30 Tuesday and Friday; and 08:30 to 13:30 Wednesday. The practice previously had a walk-in clinic provided for two hours on Mondays and Fridays of each week however funding had been removed. The practice would, however, be piloting a new walk in clinic on the same days as previously, starting in April 2015 and would monitor uptake.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours services were provided by a local provider. Access to the service was via the national NHS 111 call line. The NHS 111 team would assess the patient's condition over the phone and if it was clinically appropriate, would refer the case to the out of hours service.

The inspection was carried out to follow up a comprehensive inspection we carried on 14 May 2014 where we found the practice was not meeting the essential standards of quality and safety for:

- Cleanliness and infection control;
- Safety and suitability of premises;
- Requirements relating to workers;
- Records; and
- Assessing and monitoring the quality of service provision

It was also to rate the quality and safety of the service under our rating scheme introduced in October 2014

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We liaised with NHS West London (Kensington and Chelsea, Queen's Park and Paddington) Clinical Commissioning Group (CCG), Healthwatch Kensington and Chelsea and NHS England.

We carried out an announced visit on 25 March 2015. During our visit we spoke with a range of staff including 3 GPs, a nurse, healthcare assistant, the practice manager and four reception/administrative staff. We also spoke with 10 patients who used the service, including two members of the practice's patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed information that had been provided to us prior to and at the inspection and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, audits and risk assessments and related action plans, staff records and health information and advice leaflets.

Good

Are services safe?

Our findings

Safe track record

The practice 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there was an incident involving a patient at the reception desk who was returning a sharps box which could have put staff and patients at risk. The analysis of the incident showed that a communication breakdown due to language issues was the cause of this incident. The learning from the incident, which was communicated to all reception staff, was to recognise when there were language barriers and allow for this when trying to communicate with a patient. Staff were also advised to consider the use of language line or a make a call to a family member in an attempt to try and educate patients about the proper protocol in returning sharps boxes.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events and a summary was made available to us before the inspection for events that had occurred during the last year. These records provided a description of the nature of each event, the outcome and the learning points identified. Staff we spoke with told us the outcomes of significant events were discussed with them. We were told also that any significant events would be discussed at practice meetings and lessons learned communicated. At our inspection of 14 May 2014 we found that it was not clear how lessons learned from incidents were communicated to staff and it was not always evident how identified areas for improvement had been followed up to ensure lessons learned were implemented. At our latest inspection we saw evidence the practice had addressed this. Action had been taken to ensure significant events were discussed and recorded at practice meetings an and the minutes showing lessons learned distributed to all staff immediately after each the meeting. We saw for example, the minutes of a practice meeting on 7 January when an incident regarding a patient's continuity of care in relation to cancer diagnosis had been discussed. Lessons learned and changes in systems to follow up and record diagnoses were identified and implemented.

The practice had an incident reporting policy and procedure based on a 'significant/critical event toolkit' which included a comprehensive incident reporting form. The forms were available on the practice computer system and staff sent completed forms to the practice manager in the first instance for review. We saw records were completed in a comprehensive and timely manner and included details of outcomes and action taken. For example, the practice failed to comply with a patient's request to see information about them before being shared with an external party. This was spotted by the third party who advised patient and practice. The information provided was shredded and the practice manager met with patient to apologise and reach an agreement on what information the patient wanted to be sent to the third party. The records showed the patient was happy with final outcome.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). There was a nominated GP lead responsible for reviewing and distributing any alerts and guidelines to staff within the practice.

Reliable safety systems and processes including safeguarding

The practice had appropriate safeguarding policies in place for both children and vulnerable adults, including contact details for local safeguarding agencies. The practice had nominated GP lead for safeguarding and staff we spoke with knew who the lead was, how to recognise signs of abuse and the processes to follow. The majority of non-clinical staff had completed level 1 safeguarding training and this was planned for one, more recently recruited, member of the administration staff. Clinical staff had completed safeguarding training (GPs level 3 and nursing staff level 2). We were told that staff had received training in safeguarding of vulnerable adults but the records were not available to confirm the training undertaken. The lead GP for safeguarding provided relevant advice, instruction and support to all clinical and non-clinical staff on both child protection and safeguarding of vulnerable adults.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records and the practice kept 'at risk registers' for both children and vulnerable adults. There were regular meetings with health visitors and other health and social care professionals to review at risk children. In addition, the practice worked with the local tri-borough multi-agency safeguarding hub (MASH). The MASH brought together all key professionals in one place, to deal with child protection and sat alongside the Local Safeguarding Children Board.

There was a chaperone policy, which was visible on the waiting room noticeboard and displayed in consulting rooms we visited. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All those acting as a chaperone had undergone training and a criminal records check. Staff who acted as a chaperone had received appropriate briefing about the role at the practice and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We saw that decisions declining the offer of a chaperone were recorded in patient records. Patients we spoke with were aware of the chaperone policy and had been offered a chaperone when appropriate in accordance with the policy.

Medicines management

Prescribing activity by the practice's GPs was monitored by the CCG's medication management team (MMT). The practice had agreed with the MMT a list of medications to review with the aim of reducing unnecessary prescribing. Performance was reviewed monthly at practice meetings as well as regular discussion at local clinical learning set (CLS) meetings and the practice was benchmarked against other GP practices. The practice was also participating in a CCG-led project examining patients prescribed 10 or more medications and whether the prescriptions were still safe and appropriate. The practice received action points from the MMT which the practice's prescribing lead followed up, inviting the patient to attend a clinic for a medication review.

The practice had a medications policy and procedure in accordance with the requirements of the local Clinical Commissioning Group (CCG). We checked medicines stored in the treatment rooms and medicine refrigerators. Arrangements were in place to ensure medicines were stored securely and were only accessible to authorised staff. However, as found at our inspection on 14 May 2014, the keys were left in one of the vaccine fridges and the room where the fridge was located was left unattended with the door open. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out daily which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. No controlled drugs were kept at the practice.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice. Prescriptions were kept securely. in most respects. However, we were told they were left in the printer overnight which could compromise security.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, at a meeting in November 2014 it was noted that the practice was on target to achieve prescribing quality indicators but needed to be aware of antibiotic creep (prescribing when not needed), especially during the winter months. We saw also that the practice had in place a 'Prescribing QIPP (Quality, Innovation, Productivity and Prevention) Action Plan' dated July 2014.This was a CCG led initiative to reduce prescribing costs and the action plan included a prescribing savings plan for a range of medicines and action points for the practice to implement and review in collaboration with a local practice link pharmacist.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid

arthritis and mental health conditions. In the last year the practice had completed an audit of prescribing of high risk anti-coagulation medicine and had taken follow up action based on the outcomes.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Cleanliness and infection control

At our inspection on 14 May 2104 we found the infection control arrangements in place did not fully protect patients from the risk of infection. The arrangements to maintain appropriate standards of hand hygiene were not sufficiently robust and the standards of cleanliness were inadequate. At our inspection on 25 March 2015 we found the practice had taken appropriate action to address these issues. We saw evidence that the cleaning contract had been reviewed and increased from four to six hours per day. Cleaning standards and infection control inspections were now conducted weekly and actions audited to ensure compliance. Cleanliness and infection control risk assessments had been completed and we saw from the minutes of practice meetings cleaning standards and infection control were regularly reviewed.

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including spill kits, disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice nurse was the 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. At the time of the inspection this role was being undertaken jointly between the practice manager and health care assistant. All staff received induction training about infection control specific to their role and received periodic updates. The majority of staff had received refresher training within the last year, although evidence of this was not available for the locum nurse employed at the time of the inspection.

We saw evidence that the practice carried out weekly infection control inspections and commissioned external audits annually and that any improvements identified for action were completed on time. Minutes of practice meetings showed that cleaning and infection control were discussed regularly.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The CCG had commissioned a review of the practice's management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw the report for this which recommended the practice arranged a risk assessment for legionella to determine whether formal testing was unnecessary. The practice had arrangements in hand for this.

Clinical waste was stored appropriately and a contract was in place for its collection and disposal. Consignment notes were available for this.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and we saw evidence the last testing date was November 2014. A schedule of testing was in place. We saw evidence of calibration checks of relevant equipment, for example weighing scales, spirometers, blood pressure measuring devices, nebulisers, defibrillator and pulse oximeters.

Staffing and recruitment

Good

Are services safe?

At our inspection of 14 May 2014 we found patients were not fully protected against all the risks associated with the recruitment of staff. This was because there was insufficient evidence that all appropriate pre-employment and checks had been carried out for staff. For non-clinical staff there was no documented risk assessment of which staff needed to be subject to a criminal records check based on their responsibilities and level of contact with patients. At our inspection on 25 March 2015 we found the practice had taken appropriate action to address these issues. A recruitment checklist had been put in place to include identity checks, references, criminal records checks, right to work, professional registration, occupational health and interview questions. All non-clinical staff had been subject to a criminal records check.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the records of the two most recently recruited staff and saw that the practice followed this policy. The necessary pre-employment checks had been completed in accordance with the newly implemented recruitment checklist, although in one case a record of the identity check was not on file.

We were told that all staff received a comprehensive induction as part of the recruitment process. We saw evidence of this for a recently recruited member of staff who confirmed they had followed an induction process and been provided with a clear job description which had been effective in helping them take on their new role.

There were arrangements in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice told us that maintaining staffing levels was a challenge due to budgetary constraints. However, the practice was able to meet demand on most occasions. The practice used a recruitment agency to provide locum doctor cover during absences of the permanent doctor team and also to meet peaks in demand. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There were also arrangements in place for members of staff, including nursing and administrative staff, to cover as a far as possible each other's annual and sick leave.

Monitoring safety and responding to risk

At our inspection on 14 May 2014 we found a number of potential risks relating to safety of the premises. At our inspection on 25 March 2015 we found the practice had taken appropriate action to address the potential risks identified. A gas boiler annual service contract had been arranged. Signage had been added to all consulting rooms to warn of occupancy and the need to knock before entering. Key pad locks had been installed on all doors leading from public spaces to staff only spaces. The fire alarm was now tested monthly and a drill conducted quarterly. These activities were logged in the named fire marshal's handbook.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and health and safety information was displayed for staff to see.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Crisis referrals were made for acute mental health issues and the practice was able to facilitate same-day access to psychiatric support. Patients at significant risk were referred to the community mental health services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed that all staff had received training in basic life support in March 2014. Arrangements were in hand for update training in May 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Staff we spoke with knew the location of this equipment. We saw that the equipment was operational and we reviewed the records which confirmed that it 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

Good

Are services safe?

arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

An up to date business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included contingencies for what to do in the event of loss of surgery, utilities, telephones, IT systems and medical records. It also contained risk assessments relating to the loss of personnel, the outbreak of infection, epidemics and pandemics and risks to the premises.

Records showed that there were monthly fire alarm tests and quarterly evacuation drills. Staff received appropriate fire safety instruction during induction and the majority of staff had received update training within the last year. There was a named fire marshal. The practice had completed a fire risk assessment as part of a general health and safety risk assessment of premises and equipment completed in April 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We discussed with the practice manager, and GP partners how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Guidelines were also discussed in clinical staff appraisals in the context of professional development. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We heard, for example, that new Ebola guidance was discussed within the practice and action agreed to disseminate within the practice the guidelines on how to deal with suspected Ebola incidents.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice carried out in house spirometry, electrocardiogram (ECG) tests, asthma checks and anticoagulation and hypertension monitoring. Current smokers were screened for potential diagnosis of COPD and management. Patients were invited for routine monitoring throughout the year according to Nice Guidance and to achieve QOF targets. The practice also made considerable use of all the available community clinics such as community diabetes, respiratory, heart failure and the expert patient programmes. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as dermatology, minor surgery, rheumatology and urology, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. GPs presented case studies at clinical meetings for the management of a range of conditions. Our review of the clinical meeting minutes confirmed that this happened. We saw, for example, discussion of a the successful outcome of the management of a patient with mental health and capacity issues where it had been possible to engage with the patient to change their behaviour.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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. We heard, for example, the GPs would discuss management, best practice and best interest considerations with a patient and after offering appropriate guidance the patient's wishes would prevail.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice provided evidence of four audits completed in the last twelve months. These included two completed audit cycles where the practice was able to demonstrate improvement since the initial audit. For example, we reviewed an audit of the management of patients with a diagnosis of gestational diabetes mellitus (GDM). In the first audit in November 2013, 27 patients were identified and of these 30% had progressed to diabetes mellitus within 1-13 years of diagnosis of GDM. Data from records was incomplete and guidance provided to patients who underwent post natal screening in secondary care was not forthcoming. Several changes were proposed after the first audit including an alert message on the patient record with a diary entry for annual screening; the development of a letter to send to all patients with a documented diagnosis

Good

Are services effective?

(for example, treatment is effective)

of GDM either at postnatal check or opportunistically; and the inclusion of HbA1c (glycated haemoglobin) and body mass index (BMI) measurement in annual screening - by measuring HbA1c, clinicians are able to get an overall picture of what average blood sugar levels have been over a period of weeks/months. In the follow up audit completed between January and December 2014 it was found in 56% of cases that an up to date annual HbA1c measurement had been documented, an improvement of 41%. But recording of BMI was poor 28% of cases. The reflection of learning and action from the second audit included the addition of a recall note to records in all cases identified; focused recall and intensive support to six patients at high risk of progression to diabetes mellitus; and a further reminder letter to patients who had not engaged with monitoring to date. The results of both audits were shared within clinical meetings to help improve management of patients with a diagnosis of GDM.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 85.8% of the total QOF target in 2014, which was 3.2% below the CCG average and 7.7% below the national average. This included the achievement of 100% for several of the QOF clinical targets, scoring above both the CCG and national average. For example:

- epilepsy related indicators, 16.8% above the CCG and 10.6% above the national average;
- heart failure related indicators, 7.3% above the CCG and 2.9% above the national average;
- learning disability related indicators, 28.3% above the CCG and 15.9% above the national average;
- osteoporosis related indicators, 32.7% above the CCG and 16.6% above the national average; and
- rheumatoid arthritis related indicators, 12.3% above the CCG and 7% above the national average;

There were, however, some areas where QOF achievement was below the CCG and national average, for example:

- cancer related indicators, 7.2% below the CCG and 6.7% below the national average;
- COPD related indicators, 21.9% below the CCG and 27.7% below the national average;
- dementia related indicators, 13.3% below the CCG and 16.2% below the national average;
- peripheral arterial heart disease, 27.1% below the CCG and 28% below the national average; and
- secondary prevention of heart disease, 31.4% below the CCG and 34.6% below the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and continued to review QOf targets. The locum nurse employed at the time of the inspection was taking specific action to see patients in areas where targets needed improvements.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines, including a repeat prescribing policy. Repeat prescriptions could be ordered by email, fax, post, or in person at the practice. The on-line ordering facility was unavailable at the time of our inspection as a new web-site was being constructed. Patients were asked to allow at least 48 hours for repeat prescriptions to be processed before collection. If these were not ready on arrival the GPs were asked to sign

the prescription and the practice offered to fax a copy to the patient's pharmacy to speed up collection. Patients with repeat prescriptions were asked to see a doctor or nurse for a medication review six monthly or at annual intervals to decide whether they should continue their medication. There was an alert on the practice's computer to identify when a review was due.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with learning disabilities and mental health problems. Structured annual reviews were also undertaken for patients with long term conditions, including diabetes, COPD, and heart failure. The practice participated in local benchmarking run by the CCG through enhanced service schemes. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. These included participation in direct enhanced schemes (DES) for remote care monitoring minor surgery, influenza and pneumococcal immunisations and childhood vaccination and immunisation scheme.

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 annual basic life support. We noted a good skill mix among the doctors with special interest or

Good

Are services effective?

(for example, treatment is effective)

additional qualifications in minor surgery, dermatology, rheumatology and urology. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

There were arrangements in place for staff to receive mandatory training and additional learning and development and time off for study was provided to enable this. The practice used the NHS e-learning skills academy for health web-site for mandatory training, including equality and diversity, conflict resolution, infection control, child protection, safeguarding of vulnerable adults and fire safety. We were shown the 'training matrix' for all staff which identified when staff were trained, training that was booked and when refresher training would be due. Most mandatory refresher training was up to date but the majority of staff were due for refresher training in basic life support and safeguarding of vulnerable adults.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. We saw on staff records that appraisal reports had been completed and staff we spoke with confirmed they had received an appraisal. This included the opportunity to discuss and agree their personal learning and development needs. Staff told us they found the appraisal process helpful and felt the practice was good at supporting training and allowing time to attend courses when needed.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and there was evidence that they were trained appropriately to fulfil these duties. For example, in administration of vaccines, asthma management and medical emergencies.

Administrative staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to and there were regular opportunities to discuss work matters at practice meetings. We saw from a sample of minutes of these meetings that issues such as staff rotas, leave cover, risk assessment, prescription processes and patient confidentiality had been reviewed.

The practice had policies and procedures for managing poor performance but we did not see any evidence that there had been a need to activate these recently.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Out-of hours reports, 111 reports and pathology results were all seen and usually actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned within 24-48 hours of receipt. Hospital discharge summaries for each week were reviewed by the clinical team and the practice and followed up appropriately to ensure patients received support they required. For example, we saw in practice meeting minutes discussion of a patient who had suffered a stroke who had been visited at home by one of the GPs and had been referred to a range of support services.

Emergency hospital admission rates for the practice for the period 1 January to 31 December 2014 were at 9.17% compared to the national average of 14.4%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice had audited emergency services attendance in under five year olds in March 2015 to observe trends and identify factors influencing A&E attendances. As a result the practice identified the need to educate the practice and patients towards managing avoidable A&E attendances. Specific action was aimed at reducing viral respiratory disease and ear nose and throat (ENT) presentations, which represented the majority of cases. This included the provision of information leaflets about common problems, encouragement to visit the GP first and improved paediatric access to on-call appointments and telephone appointments.

The practice held monthly and quarterly multidisciplinary team (MDT) meetings to discuss specific patient groups with complex needs. For example, those with multiple long term conditions, mental health problems (including dementia, people from vulnerable groups including elderly

Good

Are services effective?

(for example, treatment is effective)

and frail patients, those with end of life care needs and children and pregnant women on the at risk register. These meetings were attended by district nurses, health visitors, midwives, social workers, palliative care nurses and the community matron. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We saw examples of such plans for patients with dementia and learning disabilities.

The practice participated in the local area 'Paediatric Hub' pilot to provide services and share expertise on the treatment of children. Children served by the practice were discussed with GPs at other practices and other relevant professionals including a paediatric consultant and representative from the West London Clinical Commissioning Group (CCG). This pilot had resulted in a reduction of the practice's paediatric referrals because of the up-skilling of GPs and a better integrated approach to consultant care. The practice also had a flexible approach to patients under five and would always provide an appointment urgently for a sick child. The practice had also been part of a pilot scheme that supported an MDT approach in nursing and care homes which involved a doctor attending monthly ward rounds with a pharmacist, social worker and elderly care consultant.

The practice worked with a range of external professionals to review the needs of specific groups. The practice had a weekly carers support clinic run by a voluntary group as well as the expert help of a Primary Care Navigator who was available to see all the practice's vulnerable groups to support their needs to live independently. The practice's safeguarding lead for both vulnerable adults and children attended regular locality safeguarding meetings. The practice had also participated in a two work streams with the CCG pharmacist, which has focused on patients on 10 or more medications and reducing medication errors following discharge from hospital. The practice had links with the Kensington and Chelsea Community Assessment and Primary Service, a self-referral community drug and alcohol treatment and recovery service. There were also links to other local providers of drug and alcohol rehabilitation and recovery services, including those for homeless people and rough sleepers.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. The practice used an electronic system for making referrals, the majority of which were made through the 'Choose and Book' system (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a consent protocol which was understood and applied by staff. They confirmed they would always seek consent before giving any treatment and would make entries in patient records about consent decisions where appropriate. We saw that consent forms were available for use by clinical staff, for example for minor surgery, giving vaccinations. With regard to consent for children under the age of 16, 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). There were arrangements in place to secure the consent of patients who lacked capacity, involving family, carers, social services and advocates where appropriate. Clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. The practice had attended training in capacity and the needs of vulnerable adults.

The consent protocol made provision for documenting consent for specific interventions. For example, for any procedure that carried a risk the patient was likely to consider as being substantial. In such cases the clinician carrying out the procedure would make a note in the patient's medical record detailing the discussion about the consent and the risks. We saw the log for recording consent for minor operative procedures. Written consent was

Good

Are services effective?

(for example, treatment is effective)

scanned into the patient's notes and we saw evidence of this. We noted that those responsible for delivering this service had current accreditation and we saw evidence of an observed assessment of their procedural skills.

Patients with a learning disability and mental health problems (including 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. For the future the practice would be participating the Whole Systems Pilot on integrated care in West London CCG which will focus on delivering a new approach to patient care in 2015/16.

Health promotion and prevention

There was a good range of information available to patients in the waiting area which included leaflets which could be taken away from the practice. There was also relevant health promotion information in the practice leaflet and on the practice website, although the website was currently being redeveloped.

It was practice policy to offer a health check to all new patients registering with the practice which included taking a brief medical history, blood pressure, height and weight and a urine check. GPs were informed of all health concerns detected and these were followed up in a timely way.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. This included a free cardiovascular and diabetes risk assessment and advice on how to reduce the risk. Practice data showed that 15% of eligible patients took up the offer of the health check. If any concerns were identified a follow appointment was arranged to carry out further investigations. Where appropriate patients were referred to the local exercise referral scheme, which provided supervised exercise sessions for people with a range of conditions including those with or at risk of coronary heart disease, diabetes, mild to moderate depression and obesity. We saw evidence of such referrals in patient records. All patients aged over 75 had a named GP and were offered an annual health check.

There were also mechanisms in place to support health and wellbeing of particular patient groups in line with their needs. The practice ran a smoking cessation service and the healthcare assistant had been trained to provide this service. This included routine spirometry screening. If COPD was diagnosed the patient was referred to a GP for further management of the condition. The practice regularly screened dementia patients and a recent project undertaken by West London CCG identified only two patients whose diagnosis of dementia had not been appropriately coded. We saw from comparison data with a 'buddy' practice that the practice was in most respects above the practice target diagnosis rate and QOF data showed that 88% of patients diagnosed with dementia had had their care reviewed in a face-to-face review in the preceding 12 months.

The practice provided a weekly baby clinic on a drop-in basis run by a health visitor on Thursday afternoons. Clinics were also run for child health care surveillance, contraceptive services, maternity medical services, immunisations and vaccinations. Expectant mothers and babies had medical support from nurses and health visitors, delivered in conjunction with the practice.

The practice encouraged all women to attend for regular cervical smear testing. The practice's performance for the cervical screening programme was 76%, compared to the national average of 82%. Reminders for patients who did not attend for their cervical screening test were made letter and opportunistically during appointments. Practice nurses had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes, including bowel cancer and chlamydia screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was below average for at risk groups but above average for the childhood immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 61%, and at risk groups 34%. These compared to national averages of 73% and 52% respectively.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 79% to 85% and five year olds from 71% to 92%. These compared to CCG averages of 74% to 81% for under twos and for five year olds at 64% to 87%.

Good

Are services effective?

(for example, treatment is effective)

The practice told us that the below average uptake figures for over 65s and at risk groups were due in part to patient choice The practice routinely updated its computer records with immunisation information from other services and actively chased patients who did not respond to invitations attend for immunisations. This was done by telephone, letter, text and face to face during appointments.

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 national patient survey 2014/15, the latest 'Friends and Family Test, and a survey of 120 patients undertaken by the practice's patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were broadly satisfied with how they were treated and that this was with compassion, dignity and respect. For example, for satisfaction on consultations with doctors in the national patient survey:

- 89.4% said the GP was good at listening to them compared to the CCG average of 88.8% and national average of 88.6%.
- 89.9% said the GP gave them enough time compared to the CCG average of 89.1% and national average of 91.9%.
- 90.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 95.2% and national average of 95.3%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and the majority were positive about the service experienced. Patients commented on the caring doctors and the professional attitude of staff across the whole practice. Several said the practice offered an excellent service and the staff treated them with dignity and respect. Four patients commented on difficulties in getting an appointment, one was dissatisfied with the continuity of care and another the attitude of staff. We also spoke with 10 patients on the day of our inspection, including two members of the Patient Participation Group (PPG). The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some patients' comments were less positive, including difficulty in getting to see their own GP and waiting time when they arrived for their appointment.

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 most of the consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations. However, because of the acoustics in the building some of the conversation taking place in these rooms could be overheard and two patients we spoke with commented on this. The practice recognised that this was an issue and had considered possible solutions, including the introduction of background music. However, no decisions on a resolution had been made at the time of our inspection.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, the layout of the reception area meant that it was difficult to prevent patients overhearing potentially private conversations between patients and reception staff. We saw from meeting minutes that the practice had discussed ways to improve confidentiality at the reception desk including making patients aware that they could speak to a member of staff in a private area and asking patients. The practice had also engaged an external company to carry out a risk assessment of patient confidentiality in reception and had drawn to staff attention specific action identified, including not identifying a patient by name during telephone conversations and the consideration of future building re-organisation. In the national patient survey, 88.4% said they found the receptionists at the practice helpful which was just above than the CCG average of 87.5% and national average of 86.4%.

At our inspection of 14 May 2014 we found patients records were not always kept securely and the regulations were not being met in relation to security of records. At our latest inspection we saw evidence the practice had addressed this. Previously insecure records had been moved to secure filing cabinets. Key pads had been installed on all doors leading from public spaces to staff spaces to ensure paper medical records were kept safe and away from the public. The practice had reviewed staff adherence to smart card (a credit card-sized plastic card for security in accessing computer systems) policy and had reminded staff of the importance of removing their smart card from their desktop when away from desk. A risk assessment training day had been provided in November 2014 by an external company for all staff to review the practice's level of competence in confidentiality, patient records and managing risk

Good

Are services caring?

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

The practice had a zero tolerance policy for abuse regarding any patient who is physically or verbally abusive or threatening towards staff or other patients. The policy was on display in the reception area and was stated in the practice leaflet made available to patients.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed the practice was in line with CCG and national averages in response to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 87.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86.3%; and
- 82.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81.1% and national average of 81.5%.

The responses to questions regarding nurses were marginally below averages: For example:

- 85.6% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 91%; and
- 75.6% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80.3% and national average of 84.9%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. The majority also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. However, there were one or two negative comments in these respects. Patient feedback on the comment cards we received was also mostly positive and aligned with these views.

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

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:

- 84.2% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85.3% and national average of 85.1%.
- 89.3% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86.3% and national average of 84.9%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was a system for assessing the support needs of carers and we saw the relevant carers form and poster in the reception area. A voluntary organisation ran a weekly clinic at the practice for carers. A primary care navigator supported the practice in identifying and supporting carers and was available to see all vulnerable groups to support their needs to live independently. Patients were referred to health and wellbeing schemes.

The practice took a pro-active approach to end of life care. Staff aimed to follow the Gold Standards Framework (GSF) and clinical staff and the practice manager had received related training. Doctors had links with bereavement counsellors and worked closely with the local palliative care team. They also provided direct bereavement support, by calling patients in or by visiting them. They arranged for

Good

Are services caring?

other support agencies to come to the practice and invited patients to attend. There were leaflets in the reception area to signpost patients receiving end of life care, their families and loved ones or the recently bereaved to sources of support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' healthcare needs and had systems in place to maintain the level of service provided. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided.

The West London Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice was a member of a local commissioning learning set (CLS) established by West London Clinical Commissioning Group (CCG) for the purposes of fostering collaboration and learning amongst members, benchmarking data, improving performance, sharing good practice, and generating ideas for new services or improvements to existing ones. The CCG said the practice was always available to share its thoughts on commissioning and made a positive contribution to service developments. We saw minutes of monthly CLS meetings where service improvements had been discussed and actions agreed to implement service improvements to better meet the needs of practice populations. For example, at a meeting in January 2015 we saw that information and an update had been provided by the Community Musculoskeletal (MSK) team in terms of service developments, referral guidelines, patient guide, referral process (for practices to implement immediately) and communication links.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, to improve access to appointments, a new telephone system and extra telephone lines were due to be installed in April 2015.

The practice was proactive with its care planning and case management for older patients which included the involvement of the wider multi-disciplinary team with monthly meetings and regular communication now enabled by the wider use of its new computer system. The two senior GP partners were the named accountable GP and both doctors had significant experience in the care of the elderly. They were supported by other members of the clinical team and as well as extended 15 minute appointments, 30 minutes if the patient's needs were complex. The practice had a routine visit board for housebound patients and those who had been recently discharged from hospital and each GP was expected to pick at least one patient to review. The practice was also proactive in supporting patients in their choice of end of life care planning and used the 'Co-ordinate My Care' (CMC) website to notify other agencies, such as the London Ambulance Service and out of hours providers of these wishes.

The needs of people with long term conditions were met by appropriately trained staff workforce and by providing longer appointment times. The permanent practice nurse had completed a diploma in diabetic management in autumn 2014, and the lead GP partner was undertaking a master class in diabetic management.

Benchmarked against other local practices with similar patient list sizes the practice had a higher percentage of children under age five. To meet the needs of this population the practice ran dedicated nurse and baby clinics and a health visitor led drop-in clinic on Thursday afternoons. There were follow up arrangements in place following the birth of a child, to check on progress and offer support to the mother and child. These included post-natal checks to ensure the health needs of both child and mother were considered at an early stage and the offer of immunisations. Information leaflets were available in the reception area relevant to mothers, babies, children and young people.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Staff told us they had access to an interpretation service for patients for whom English was not a first language and we saw signs offering this service in the reception area. There was an e-mail service, for deaf patients. Staff were aware of when a patient may require an advocate to support them and the practice had access to advocacy services available for patients, for example, to support and where necessary secure the consent of patients who lacked capacity.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had 93 patients on its 'enduring mental illness' register and 61 patients for whom they, in conjunction with the mental health team, shared the responsibilities of prescribing. Longer appointments or home visits were arranged for this group of patients if required.

The practice had a small number of homeless people on its register, although they were not truly homeless but were experiencing difficult issues with housing departments or social services. The primary care navigator supported these patients in accessing and engaging with those services.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. The stairs to the second floor treatment rooms

were a potential barrier to older people but arrangements were made for doctors and nurses to see them on the ground floor. There were access enabled toilets and baby changing facilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. The reception desk had low access for wheelchair users, and a hearing loop. Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

Most patients we spoke with said they did not mind whether they saw a male or female doctor, although there was only one male doctor so the practice may not always be able to meet patients' requests if they did wish to see a male doctor.

The practice had an equal opportunities policy. Staff were made aware of the policy as part of the induction process and staff we spoke with understood patients' equality and diversity needs covering a diverse population of patients. The GP partners, practice manager and four of the reception/administration team had completed equality and diversity training.

Access to the service

The surgery was open from 08:00 to 20:00 and Monday and Thursday; 08:00 to 18:30 Tuesday and Friday; and 08:00 to 13:30 Wednesday. Appointments were available from 08:30 to 20:00 Monday and Thursday; 08:00 to 18:30 Tuesday and Friday; and 08:30 to 13:30 Wednesday. The practice previously had a walk-in clinic provided for two hours on Mondays and Fridays of each week but CCG funding had been removed. The practice would, however, be piloting a new walk in clinic on the same days as previously, starting in April 2015 and would monitor uptake.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours services were provided by a local provider. Access to the service was via the national NHS 111 call line. The NHS 111 team would assess the patient's condition over the phone and if it was clinically appropriate, would refer the case to the out of hours service.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP. Visits were made monthly to a local care home which involved a doctor attending ward rounds with a pharmacist, social worker and elderly care consultant.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice in line with local and national averages in these areas. For example:

- 86.9% were satisfied with the practice's opening hours compared to the CCG average of 79.5% and national average of 75.7%.
- 78% described their experience of making an appointment as good compared to the CCG average of 79.1% and national average of 73.8%.
- 62.6% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63.5% and national average of 65.2%.
- 81.2% said they could get through easily to the surgery by phone compared to the CCG average of 86.3% and national average of 74.4%.

The majority of patients we spoke with or received comments cards from did not raise concerns about the

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments system. However, a minority of patients said it was difficult to get an appointment that suited their needs. Patients could call at 8am for morning appointments and at 1.30pm for the afternoon.

surgery. 15 emergency slots were available daily. We were told that patients who asked for an urgent appointment were given one and the practice never turned anybody away. The practice also provided telephone consultations. There was an online booking system for appointments.

The practice recognised that meeting the needs of all patients regarding access to appointments was a continuing challenge and was constantly seeking ways to improve this. It was anticipated that the introduction of a new phone line system and extra lines in April 2015 would improve patient satisfaction with the appointments system.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice manager was the complaints manager and the lead GP partner led on investigating clinical complaints. The complaints procedure explained how patients could pursue matters further with other organisations if they were dissatisfied with the handling of their complaint, including the Parliamentary and Health Service Ombudsman (PHSO).

We saw that information was available to help patients understand the complaints system. The practice had a complaints procedure and a complaints leaflet and form were available in the reception area. The leaflet provided patients with information about the complaints process and who to contact if they were dissatisfied about the outcome. There was also information about making complaints in the practice leaflet and on the practice website. Patients we spoke with had not needed to make a complaint about the practice.

We were provided with an analysis of complaints received in the last year which included a summary of the complaint, action taken, the outcome and lessons learned. We looked at the records of three complaints received in the last year. We saw that these were dealt with in a timely manner. The letter of response offered an explanation and apology where appropriate.

Staff we spoke with were generally aware that patients could complain about the service and were aware of the complaints procedure document. We were told that learning from complaints was discussed within the practice and the practice's analysis of complaints recorded a number of instances where lessons had been learned which resulted in changes in practice. For example, in relation to a complaint about sharing patient information with other agencies where staff were reminded when communicating with other services to ensure that only appropriate patient information was included. We also saw evidence of discussion of complaints and lessons learned in the minutes of meetings we reviewed and complaints were a regular item on the agenda.

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 vision was to make a difference to the lives and healthcare of its patients. Its stated mission was to put the patient first, delivering help to those who need it most. However, at our inspection of 14 May 2014 it was not clear how the practice vision was articulated and not all staff were aware of this. At our latest inspection we saw evidence the practice had taken steps to address this. We saw that the findings of the previous inspection had been discussed at practice meetings with a view to improving communication. The practice ethos was also set out clearly in the practice's presentation at the start of the inspection under the by-line 'It begins with a 'C' covering eight elements including for example, caring; confidential; clinically robust, collaborative and communicative. Staff we spoke were now able to articulate the essence of the practice ethos and it was clear that patients were at the heart of the service they provided. They felt generally that communication within the practice was effective.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available to staff on the practice's computer system within the practice. There was a staff handbook containing appropriate human resource policies. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff. At our inspection of 14 May 2014 we found that there was no systematic review of practice policies and

procedures and there was no formal process for communicating changes to staff and ensuring they had read and understood the new policy or procedure. At our latest inspection we saw evidence the practice had taken steps to address this. We saw that policies had been reviewed and noted from meeting minutes that they had been drawn to the attention of staff with instructions to familiarise themselves with the policies, including whistleblowing, safeguarding and equality and diversity.

The leadership structure was not formally stated but there were named members of staff in lead roles. For example, there were named leads for safeguarding, infection control, complaints and HR matters. At our inspection of 14 May 2014 not all staff we spoke with knew who the leads were. However, at our latest inspection this had been addressed. Staff knew the leads and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data showed the practice performed above other practices in the local CCG area in about 40% of the indicators in the year ending April 2014 and in many of them scored 100%. QOF data was regularly discussed at clinical team meetings and action planning put in place to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a repeat audit of the management of patients with a diagnosis of gestational diabetes mellitus (GDM); an audit of patients prescribed anticoagulants and an audit of emergency services attendance in under five year olds. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice had arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice regularly monitored and reviewed risks to individual patients, using specific risk assessment and management tools where appropriate, and updated patient care plans accordingly.

At our inspection of 14 May 2014 it was not clear how recommended controls identified from the practice's health and safety risk assessment were communicated within the practice and followed up and implemented. In addition, the systems in place to identify, assess and manage other risks to the health, safety and welfare of people who use the service and others were not effective. At our latest inspection we saw evidence the practice had taken steps to address these findings. A risk assessment training day had been provided in November 2014 by an external company for all staff to review the practice's level

Are services well-led?

Good

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

of competence in a number of areas including managing risk. Appropriate fire alarm testing and evacuation drills were now in place and steps had been taken to improve the safety and security of the premises.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice

We saw from minutes that staff meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Staff felt that the practice worked well as a team and provided mutual support. Staff felt that communication within the practice was generally good.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction and equality and diversity which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received and the NHS friends and family test. The practice had a patient participation group (PPG) where members met twice a year with the practice manager to discuss issues relating to improving patients' experiences. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice manager showed us the minutes of the two most recent PPG meetings in October 2014 and March 2015. We saw, for example, the imminent introduction of a new phone system had been discussed and the group agreed this was a positive move that would be welcomed by all patients to improve telephone access to appointments. We saw also that at the group's request it had been agreed the practice's complaints log would be shared with the group to allow them to make constructive comments and suggestions on any identified trends.

We spoke with two members of the PPG who told us of the useful opportunities to hear though the group about important developments at the practice, and to put forward ideas and suggestions. They said the attendance at PPG meetings varied between five and twelve patients. They felt the effectiveness of the group could be improved by recruiting to the membership to align it more closely to the practice population but this should not reflect negatively on the practice as attempts had been made to address this. They were receptive to the idea of appointing a group member as an independent chair and to spend time at the practice to encourage joining/participating in the PPG, which had been raised by the practice as a result of feedback at the inspection.

We noted the feedback from the March 2015 NHS friends and family test. This showed 73% of patients would highly recommend the practice and 17% would likely recommend the practice to friends and family. The action plan from the test included communication of the results with PPG members; engaging more fully with continuity of care as a clear indicator of patient satisfaction; and extending the friends and family test more widely to include other areas of the practice population and not just those who come into the surgery.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 staff records and saw that they received regular appraisals and learning and development needs were linked to the appraisal process through individual personal development plans.

Are services well-led?

Good

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

The practice had completed reviews of significant events and other incidents which included lessons learned. Staff we spoke with confirmed that the outcomes of significant events were discussed with them and we saw evidence of this in practice meetings minutes. For example, we saw discussion of a case of a patient with cancer and another where the capacity of a patient to refuse treatment had been reviewed. Lessons learned and resulting action were identified in both cases.