The Randolph Surgery

Quality Report

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

Ratings

Overall rating for this service	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 Randolph Surgery on3 December 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 for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

Summary of findings

- The practice had set up a monthly paediatric clinic attended by a hospital paediatric registrar with support from a paediatric consultant and two of the practice GPs on a rota basis, to meet the needs of families with young children.
- The practice had supported patients living in two local hostels waiting re-housing who had complex medical needs. The practice routinely called these patients to remind them to attend booked appointments and there was an agreement with the hostel staff to support attendance in order to minimise missed appointments and ensure health care could be offered.

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

Importantly the provider should;

- Implement a protocol for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).
- Ensure staff who may be called upon to act as a chaperone have received relevant training.
- Ensure regular calibration checks of medical equipment are carried out, for example the spirometer.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. For example, the practice kept a record of all significant events that had occurred including learning points and action plans to improve the safety of the service. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. All staff had received appropriate role specific training in safeguarding children and vulnerable adults. The practice was equipped to manage medical emergencies and all staff had been trained in basic life support. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from 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. This included assessing capacity and promoting good health. The practice performed Clinical Commissioning Group (CCG) led clinical audits of unplanned hospital admissions and secondary care referral rates and used results to improve services and care for patients. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff, including 360 degree feedback from colleagues for clinical staff. Staff worked with multidisciplinary teams and met monthly to discuss management of patients with complex needs.

Are services caring?

Good

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

Summary of findings

staff support patients who were carers and information was available in the waiting room and on the practice website to signpost them to support services, such as the Westminster Carers Network.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were generally satisfied with the appointment system. There was access to telephone triage with the duty doctor for urgent issues as well as a number of bookable same day appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. The building was accessible to wheelchair users. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence the practice learned from complaints and made improvements to the service as a result.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a patient charter leaflet that set out a clear vision and the standards to achieve in order to deliver this vision. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which were acted on. The patient participation group (PPG) was actively involved with the practice and contributed to changes made to the service as a result of feedback. Staff had received inductions, regular performance reviews and attended staff meetings and social events.

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. We were told due to the smaller numbers of older patients in the practice population the clinical staff knew these patients well and would respond promptly if they required appointments. The practice would routinely offer elderly patients appointments at the end of surgery if acceptable, to allow more time to manage any complex needs. Home visits were routinely available for patients who were housebound. The practice has access to the Rapid Access Elderly Care Service at a local hospital which allows prompt specialist geriatric assessment for complex elderly patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. They actively referred patients with long term conditions to a local community multidisciplinary team of staff from health and social care services who provide community support to patients with chronic heart disease, Chronic Obstructive Pulmonary Disease (COPD), depression, diabetes and high blood pressure. The practice offered practice nurse led annual review appointments with extended time slots for patients with long term conditions. The practice nurses performed spirometry for patients with chronic lung diseases. All patients with COPD were offered referral to the community COPD services. All newly diagnosed patients with diabetes were referred to the community diabetes services for education and support.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There was a weekly joint well baby clinic with the GP, nurse and health visitor that offered child health surveillance and immunisations. The practice held a monthly paediatric clinic attended by paediatric doctors and practice GPs to meet the needs of families with young children and feedback on this service had been positive. The practice offered cervical screening in line with current national guidelines.

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 offered extended hour appointments to ensure patients who worked or were in full time education had access to appointments. The

Summary of findings

telephone triage service allowed patients to request a call back from the doctor allowing patients to access urgent medical advice without having to attend the practice. There was no facility to book appointments or request repeat prescriptions on line, however we were told this would be available from the new electronic notes system from March 2015.

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 maintained a register of patients with learning disabilities and these patients were invited to annual review health checks with 30 minute appointment slots. The practice supported patients living in two local hostels with complex medical problems and routinely offered telephone reminders to attend appointments for review.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).The practice referred patients experiencing poor mental health to a local community mental health multi-disciplinary team of GPs, social workers and community navigators to support patients with mental health issues. They offered talking therapies, advice on benefits or employment and signposting to community services.

Summary of findings

What people who use the service say

During our inspection we received 37 Care Quality Commission (CQC) comment cards that patients had completed and spoke with nine patients including four members of the patient participation group (PPG). Overall the feedback given was positive. The majority of patients were satisfied with the care they received and felt that staff at the practice treated them with compassion, dignity and respect. This was similar to the findings of the national GP patient survey published in July 2014 which found that 74% of respondents described their overall experience of the practice as good and 78% said that they would recommend the practice to someone new to the surgery.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Implement a protocol for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).
- Ensure staff who may be called upon to act as a chaperone have received relevant training.
- Ensure regular calibration checks of medical equipment are carried out, for example the spirometer.

Outstanding practice

- The practice had set up a monthly paediatric clinic attended by a hospital paediatric registrar with support from a paediatric consultant and two of the practice GPs on a rota basis, to meet the needs of families with young children.
- The practice had supported patients living in two local hostels waiting re-housing who had complex medical needs. The practice routinely called these patients to remind them to attend booked appointments and there was an agreement with the hostel staff to support attendance in order to minimise missed appointments and ensure health care could be offered.

The Randolph Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice manager and an expert by experience. They were granted the same authority to enter the premises as the CQC Inspector.

Background to The Randolph Surgery

The Randolph Surgery is a well-established GP practice located in the London Borough of Westminster and is part of the NHS Central London Clinical Commissioning Group (CCG) made up of 36 GP practices. It provides primary medical services to approximately 7,300 patients.

The practice holds a Personal Medical Services (PMS) contract and is commissioned for the provision of local enhanced services which include extended hours, anti-coagulation services and phlebotomy.

The practice team comprises of two female GP partners, three female and one male salaried GP, two part time female practice nurses, one female Health Care Assistant, a part time female practice nurse administrator, a practice administrator, a clinical co-ordinator, a head of reception, five receptionists, a clerical worker and a GP administrator.

The practice opening hours are 7.30 am to 6.30 pm Mondays, Thursdays and Fridays and 7.30 am to 8.00 pm on Tuesdays and Wednesdays. The practice has opted out of providing out-of-hours (OOH) services. The details of the OOH service are communicated in a recorded message accessed by calling the practice when it is closed and on the practice website. Patients are also directed to two neighbouring GP practices open 8.00am to 4.00 pm Saturdays and Sundays if they require GP review. The practice provides a wide range of services including checks for diabetes, chronic obstructive pulmonary disease (COPD), asthma review and child health care. The practice also provides health promotion services including a flu vaccination programme, cervical screening and once weekly men's health clinic run by the male salaried GP.

The practice population is predominately 25 – 54 year olds, with fewer patients over 70 years of age and a higher number of 0 – 4 year olds compared to the England average. There are a higher number of patients in paid work or full time education compared to the England average.

Why we carried out this inspection

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

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.

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

Detailed findings

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 we hold about the practice and asked other organisations to share what they knew. We met with NHS England, NHS Central London Clinical Commissioning Group (CCG) and Healthwatch Central West London and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 3rd December 2014.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, head of reception, reception and administration staff. We also spoke with nine patients who used the service and representatives from the practice patient participation group (PPG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record. For example, where an error had been made we saw that the processes for investigating the incident led to changes to protocol and practice to improve the safety of patients.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. A significant event monitoring and analysis procedure document was available on the shared drive and staff were aware of this. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and the practice produced a yearly report of all significant events that had occurred. There was evidence that the practice had learned from these and that the findings were disseminated to staff verbally and at the practice meeting. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the GP partners for review that were then submitted to NHS Westminster for recording. The form included information on the date of event, who was involved, a description of the event, immediate actions taken and learning points. We tracked eight incidents and saw records were completed in a comprehensive manner including the date the significant event had been discussed at the practice meeting. We saw evidence of action taken as a result. For example, following an event where a breach of confidentiality had occurred at reception, the case was discussed at the practice meeting to re-iterate the confidentiality policy and the head of reception ensured all staff were up to date with information governance training. Where patients had been affected by something that had gone wrong, in line with practice policy they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a safeguarding children policy and an at risk adults policy available on the shared drive. There was a named GP lead for safeguarding and staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. We looked at training records which showed that all staff had received relevant role specific training on safeguarding, GPs had been trained to level 3 in child protection, practice nurses to level 2 and administration staff to level 1. Staff we spoke with were knowledgeable in recognising potential signs of abuse, were aware of their responsibilities and understood the reporting processes if they suspected that abuse may have occurred.

There was a system to highlight vulnerable patients on the practice's electronic records. For example, there was a 'yellow flag' on a patient's electronic record to alert staff if they were at risk of abuse.

The practice had a chaperone policy which set out guidelines for staff to follow for the protection of patients and staff from abuse or allegations of abuse. We were told that administration staff had not received chaperone training but were very rarely asked to act as a chaperone as female clinical staff were available for this role. Administration staff who may be called upon to act as a chaperone had been Disclosure and Barring Service (DBS) checked.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and we saw daily temperature checks were monitored.

Good

Are services safe?

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. Vaccines were administered by qualified nursing staff using up to date directions that had been produced in line with legal requirements and national guidance.

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. For example, all anticoagulation blood test results were sent to the duty doctor who would review them on the same day and manage Warfarin dosing.

All repeat prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We reviewed the weekly and daily cleaning schedules which were provided by an external contractor. The cleaning contractor conducted monthly cleaning audits and we reviewed the results for the previous two months which showed 98.5% and 99% compliance with cleaning standards respectively. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a control of substances and hazardous to health (COSHH) policy that was available for staff to access on the shared drive.

The practice had an infection control policy available on the shared drive that had been reviewed and updated in January 2014. Training records confirmed all staff had received training on infection control as part a mandatory training program. Hand hygiene formed part of the mandatory training during induction for new staff. There was evidence that regular infection control audits were carried out to monitor compliance with infection control policies.

The practice had an occupational health screening policy that outlined the immunisation requirements for clinical and administrative staff. There was a needle stick injury procedure and staff were aware of the process to follow if they sustained such an injury. 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 practice did not have a protocol for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).

Equipment

Medical equipment, for example refrigerator and blood pressure measuring devices, were checked and calibrated yearly by an external contractor and were next due in June 2015. The practice was not performing quality control checks on the current spirometer but we were told they were in the process of purchasing a new one that would be compatible with the new electronic record system and calibration of this machine would be checked.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date in June 2014. A schedule of testing was in place.

Staffing and recruitment

The practice had a recruitment policy and checklist that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at confirmed that all staff had completed or were in the application process of criminal records check through the DBS. All clinical staff were registered with the appropriate professional bodies.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that there were enough staff on duty.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included a health and safety policy that was reviewed and updated in April 2014 and estate management policies. Fire alarms were checked weekly and recorded and fire drills were performed six monthly. Staff had completed fire awareness training online in February 2014. There was evidence that risk assessments were conducted, for example a COSHH risk assessment, health and safety checks and occupational health assessments had been completed.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and were due an update in February 2015. Emergency equipment was available including access to oxygen, nebuliser machine and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia, seizures, breathing difficulties, infection, chest pain and morphine overdose. 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.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Copies of the plan were held off site in the event that the premises could not be accessed.

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.

The GPs told us they were all generalists and there were no specific leads in specialist clinical areas, although one of the salaried GPs offered a weekly Men's Health Clinic. One of the practice nurses was the clinical lead for learning disabilities and arranged annual reviews for these patients.

Data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing showed it was comparable to similar practices in the local area.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral including referrals for suspected cancer made within two weeks. The practice took part in regular CCG-led peer review of secondary referrals and made changes to practice to improve referral rates. For example, it was noted urgent two week wait referrals to breast services had been higher than the CCG average and as a result the practice created a new referral policy to ensure patients were referred to the most appropriate service according to their age and symptoms. Subsequent audit of this new policy found two week referral rates had reduced over six months to be more in line with the CCG average.

We saw no evidence of discrimination when making care and treatment decisions and that the culture in the practice was that patients were referred based on clinical need only.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and medicines management.

One of the GP partners had completed a project to improve access to GP appointments at the practice as a result of feedback from patients and staff that suggested the previous 48 hour appointments system was unpopular. Following research through literature review and visiting a local practice with similar demographics, they implemented a new appointment system to provide same day appointments and telephone triage with the duty doctor. Since implementation the practice has conducted regular audits of the appointment system to monitor and improve the service. For example, an audit was performed in June 2014 to assess demand for same day appointments and rapid access telephone appointments to ensure the time was allocated appropriately. They found that allocating one third of appointment slots to same day appointments was appropriate but that demand for the telephone triage was high at times with at least 20% of calls being taken up with medication review and discussing normal pathology results. As a result the practice stopped instant access to telephone consultation to discuss normal test results and instead patients would be informed of normal blood results signed off by a GP by reception staff when the patient called.

An audit into accident and emergency (A&E) attendances whilst the practice was open, was carried out before implementation of the new appointment system in 2011 – 2012 with a follow up review in 2013 – 2014. This showed the rate of inappropriate A&E attendances that could have been seen in the GP surgery had reduced from 42% to 13% suggesting the new appointment system was improving access to appointments during normal practice opening hours. It was noted in the follow up audit that there continued to be some patients attending A&E or walk-in-centres between 6.30 – 8.00 pm with problems that could have been dealt with at the GP surgery. As a result reception staff were asked to promote the practices extended hours when patients attended the practice.

The GPs told us clinical audits were often linked to medicines management information, CCG guidelines and as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice had completed nine QOF related audits in the last twelve months. For example, we saw an audit into unplanned hospital admissions between July – October 2013 as part of CCG guidance. This found that of the 30 unscheduled admissions audited five

Good

Are services effective?

(for example, treatment is effective)

could have been prevented and four of were vulnerable elderly patients that may have been prevented with additional support in the community. These results were discussed at a CCG peer review meeting with other local practices to identify proactive ways to improve access to community services for vulnerable elderly patients.

The practice also used the information collected for QOF and performance against national screening programmes, to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes, asthma, high blood pressure, learning disabilities, palliative care and mental health. This practice was not an outlier for any QOF clinical targets.

The practice participated in the CCG Prescribing Incentive Scheme that encourages review of prescribing practices for specific drugs including warfarin prescribing and monitoring, antibiotic prescribing and Non Steroidal Anti-Inflammatory Drugs. They had also completed a recent audit to identify potentially dangerous poly-pharmacy prescribing in the elderly. This involved reviewing repeat prescriptions for selected elderly patients and identifying hazardous medications that may interact. The results were disseminated to the clinical staff and local pharmacy team via email to raise awareness of these issues.

The practice had a protocol for repeat prescribing. The practice nurse would issue repeat prescriptions only according to a pre-set authorisation limit. They had received in house training for this and followed printed guidelines. Any repeat prescriptions that required authorisation by a GP were passed on to the duty doctor. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had a palliative care register and had two monthly multidisciplinary meetings with the palliative care team to discuss the care and support needs of patients and their families. During these meetings care plans were reviewed and 'Co-ordinate My Care' documents updated if appropriate.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or improved to other services in the area.

For example, the practice attended a CCG peer review meeting of unplanned emergency admissions and data from 2013 showed the rate of emergency admissions was better than the CCG average.

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

Two practice nurses had recently joined the practice (June and October start dates) and so had not yet received their annual appraisal. One had an appraisal date booked in March 2015 and the other was in the process of arranging a date for appraisal. We saw the practice had an appraisal procedure document that outlined the yearly procedure for both clinical and non-clinical staff including development of a personal development and training plan. Clinical team member's appraisal also included 360 degree feedback from colleagues in the practice. Administration staff were subject to a one month, three month and six month appraisal following employment commencement and annually thereafter.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, training for using spirometry equipment and on the use of anticoagulation software to assist warfarin dosing. The health care assistant had received formal training in phlebotomy.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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. The practice had a pathology result management policy outlining the responsibilities of all relevant staff in passing on and acting on pathology results received. Results were received

Good

Are services effective?

(for example, treatment is effective)

electronically from the pathology service and were allocated for review daily to the doctor who requested the test, except for all INR and bowel screening results which were allocated to the duty doctor. Normal blood results were assigned to reception staff to pass on to the patient. The GP reviewing the results processed any abnormal findings. Patients were told to call for blood test results after three days and to allow three to five working days for diagnostic test and specimen results.

The practice had a procedure for reviewing and processing clinical letters and discharge summaries received from secondary care. On arrival the reception staff date stamped the correspondence and passed it on to be scanned. Significant diagnoses or procedures were coded by the GP and the patient notes updated. There was a rota to ensure this workload was distributed evenly amongst the GPs. Any medication changes were updated by the practice nurse. The practice maintained an unplanned admission register and there was a named member of staff who contacted patients on discharge to discuss the admission and establish if it could have been prevented.

Patients at the practice were able to access services from two local surgeries that were open at the weekend, but did not have two way patient information sharing between the practices. We were told by staff this would be in place once all practices operated the same clinical system and a data sharing agreement had been agreed between the practices.

The practice held multi-disciplinary (MDT) team meetings monthly attended by the clinical team, district nurses and community matron to discuss the needs of complex patients and identify vulnerable patients in need of visits. The Community Matron who attended the meetings had links with the community heart failure team and would refer appropriate patients as required. Every two months palliative care nurses attended the MDT meetings to discuss and review care plans of patients on the palliative care register and update where appropriate 'Co-ordinate My Care' documents.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, information was received electronically and by post from out-of-hour and secondary care services. Referral letters were typed by doctors with the use of pre-created templates so that they contained standardised information relevant to the referral. There was a referral process followed including procedures for urgent referrals in line with national guidance.

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We were told by staff they would be transferring to a new electronic record system, System One, in January 2015.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies although use was infrequent to do the low numbers of teenage patients in the practice population. (These competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice offered NHS Health Checks to all its patients aged 40 to 75 years performed by the Health Care Assistant. The practice held a Men's Health clinic every Thursday which was run by one of the salaried GPs with a specialist interest in this area.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and offered annual review to these patients. There were 11 patients on the register and all annual reviews were due to be completed by the end of December 2014. Prior to the annual health check patients with learning difficulties were sent a health action plan in an easy to read format for them or their carer to complete. The practice nurse worked

Good

Are services effective?

(for example, treatment is effective)

alongside the Westminster Learning Disabilities Partnership Lead to discuss cases. For example, when a female with learning disabilities may be considered a candidate for long acting reversible contraception.

Similar mechanisms of identifying 'at risk' groups were used for patients receiving end of life care and they were offered further support in line with their needs. All patients with diabetes are referred to structured expert education programs at the local hospital to improve knowledge and facilitate self-management. The practice had also identified the smoking status of 84% of patients over the age of 16 in 2013-2014 and actively offered referral to local smoking cessation services.

The practice performance for cervical smear uptake was 79.1% for 2013 - 2014 which was comparable with other practices in the local CCG area. The practice nurse told us they were proactive in ensuring smears taken had a documented result in the patient's notes and would follow up on any outstanding results. They performed a clinical audit into inadequate smear results to monitor and improve the service. The practice offered bowel and breast screening services in line with national guidance. There was a procedure in place if a patient did not respond to the bowel screening kit - a yellow flag was put on the electronic records so this could be discussed and reviewed when the patient next attended the practice.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Uptake rates for flu immunisation in over 65 year olds was 76.8% in 2012 – 2013 which was average for the CCG. Childhood immunisation rates for the period 2013 – 2014 were high; between 74% – 91% at 12 months and 24 and between 74% - 94% at five years, depending on the vaccination. Patients who missed immunisation appointments were called on the day to arrange another appointment by the clinical co-ordinator administrator and if there was second missed appointment a letter was sent out the child's parent. During the flu vaccination season locum nurses were used to support the service.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, helpful, and compassionate towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice staff and that they were treated with kindness, dignity and respect. Many of the 37 completed Care Quality Commission (CQC) comment cards we received referred to staff as compassionate, respectful, caring, professional, attentive and friendly.

Evidence from the latest GP national patient survey published by NHS England in July 2014 showed that patients were satisfied with how they were treated. Seventy-five per cent said that the last GP they saw or spoke to was good at treating them with care and concern and 85% found the receptionists helpful. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with nurse. Seventy-eight per cent of respondents said that their nurse was good at listening to them and 78% said their nurse gave them enough time.

The practice had a chaperone policy and patients had the option to see a male or female GP when booking an appointment. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Patients we spoke with and feedback from CQC comment cards indicated patients felt confidentiality was maintained by the practice.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 85% felt the GP was good at listening and 73% felt the GP was good at explaining treatment and results..

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received and that they were provided with sufficient information to make informed decisions about their care. Patient feedback on CQC comment cards we received reflected this feedback.

The practice did not have access to a telephone translation service. However, interpreters could be booked in advance and several of the clinical and administration staff spoke different languages and could provide translation services if required.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. CQC comment cards we received reflected this feedback. Information in the waiting room and on the practice website signposted patients to a number of support groups and organisations for example Age UK, MIND and shelter.

The practice had a carer's policy that included information on identifying and supporting carers. The electronic record system alerted GPs if a patient was a carer. We saw written information available in the waiting room and on the practice website for carers to raise awareness of support available to them for example, Carers UK Support Network. The Patient Participation Group (PPG) was involved in improving carer awareness and representatives from the Westminster Carers Network had attended PPG meetings in the past to discuss the support available in the area for carers.

Procedures were in place for staff to follow in the event of the death of one of their patients. Staff were informed of all patient deaths which was communicated by email and at weekly and monthly practice meetings. Community services if involved with the patient would be informed.

The practice maintained a list of patients receiving end of life care and this was available to the out of hours provider. Every two months representatives from the community palliative care team attended the practice multi-disciplinary meeting to discuss the needs of patients receiving end of life care and update Co-ordinate My Care documents where appropriate.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and 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 had a smaller over 75 year old population compared to the national average and did not provide care to any local nursing homes. We were told due to the smaller numbers the clinical staff knew their elderly patients well and responded promptly if they required appointments or home visits. The GPs told us they would routinely offer elderly patients appointments at the end of surgery if acceptable to allow more time to manage any complex needs. Home visits were routinely available for patients who were housebound. The practice has access to the Rapid Access Elderly Care Service at a local hospital which allows prompt specialist geriatric assessment for complex elderly patients.

During an audit of unplanned admissions to hospital it was noted four of these admissions were for vulnerable elderly patients that may have been prevented with community support. As a result the practice planned to employ a Health Worker for the Elderly to support vulnerable elderly patients and help them navigate community support services that are available.

The practice offered annual review appointments with the practice nurse for patients with long term conditions such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). These appointments were extended time slots to allow for full assessment of patients needs. The practice nurses performed spirometry tests for patients with chronic lung diseases in extended appointments. We were told all patients with COPD were offered referral to the community COPD services and all newly diagnosed

patients with diabetes were referred to the community diabetes services for education and support.

The practice actively referred patients with long term conditions to Wellwatch, which is a multidisciplinary team of staff including a GP, senior nurse and health and social care co-coordinator, who provide phone and face to face support to patients with chronic heart disease, COPD, depression, diabetes and high blood pressure. They offered healthcare support and signposting to care services.

The practice had a higher population of 0 – 4 year olds compared to the national average but fewer teenagers. There was a joint well baby clinic with the GP, nurse and health visitor every Thursday that offered child health surveillance and immunisations. One of the partners had set up a monthly paediatric clinic attended by a hospital paediatric registrar with support from a paediatric consultant and two of the practice GPs on a rota basis to meet the needs of families with young children. The clinic received referrals from the practice itself and two other local surgeries. We were told by staff that feedback on this service had been positive. The practice had initiated a pre and post-natal drop in service for new mothers with limited local social support, to help them transition from employment to parenthood. The service ran during 2011/2012 until funding ceased. The practice offered cervical screening in line with current national guidelines.

The practice offered extended hour appointments twice a week until 8.00pm and appointments daily from 7.30am to ensure patients who worked or were in full time education had access to appointments. The telephone triage service allowed patient's to request a call back from the doctor within two hours of the request, allowing patients to access medical advice without having to attend the practice. There was no facility to book appointments or request repeat prescriptions on line, however we were told this would be available from the new electronic notes system from March 2015 and information regarding this future service was available on the practice website.

The practice maintained a register of patients with learning disabilities and these patients were invited to annual review health checks with 30 minute appointment slots. Patients with learning disabilities were offered earlier appointments to minimise any distress from potential long waits. The practice looked after approximately 20 patients living in two local hostels. We were told these patients often had complex medical problems with poor adherence to medication and attendance at appointments. The practice routinely called these patients to remind them to

Good

Are services responsive to people's needs?

(for example, to feedback?)

attend booked appointments and there was an agreement with the hostel staff to support attendance in order to minimise missed appointments and ensure health care could be offered.

The practice actively referred patients experiencing poor mental health to the Primary Care Plus Mental Health Services. This was a NHS community service in Westminster consisting of a multi-disciplinary team of GPs or primary care liaison nurses, social workers and community navigators to support patients with mental health issues. They offered talking therapies, advice on benefits or employment and signposting to community services. We were given two case examples by the GPs of occasions they have used this service to support patients recently discharged from mental health services.

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, the current appointment system was implemented in 2012 as a result of feedback from the PPG suggesting patients were not satisfied with previous 48 hour appointment system.

Tackling inequity and promoting equality

The practice did not have access to telephone translation services. However, interpreters could be booked in advance and members of the clinical and administration team spoke four additional languages between them.

The practice had an Equality and Diversity Policy and Equal Opportunities Policy for staff that was both available for all staff on the practice shared drive.

The practice was situated on a single level which was accessible to wheelchair users. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 7.30 am to 6.30 pm Mondays, Thursdays and Fridays and 7.30 am to 8.00 pm on Tuesdays and Wednesdays. Comprehensive information was available to patients about appointments on the practice website and this included how to arrange urgent appointments and home visits. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Two local practices were open 8.00am – 4.00pm Saturday and Sundays and patients from the practice were able attend these practices for medical care.

The practice operated a same day telephone call back service for urgent issues. Patients were advised to ring the practice during set times throughout the day and reception staff would arrange a call back from the duty doctor within two hours of the request. We were told the duty doctor would respond to calls out of the set times if it regarded an unwell child or unwell adult with red flag symptoms. The duty doctor would call back up to three times if they did not get through to the patient on initial call back. The outcome of the call would either be advice over the phone or arrangement of a face-to-face appointment that day, or a home visit if the patient was housebound. All patients under the age of 5 years would routinely be triaged to the duty doctor. In addition to this service the practice offered a fixed number of 'first come first served' same day convenience appointments for non-urgent issues. Patients could book routine appointments up to three months in advance. Longer appointments were available for patients who needed them and those with long-term conditions. Routine clinics were structured with frequent catch up slots for the GPs to prevent surgeries over-running and reducing patient wait times.

Patients were generally satisfied with the appointments system. Feedback from patients we spoke with described that appointments were easy to access, but there were occasional long waits to be seen. This was reflected in the results of the National GP Survey 2014 as 85% of respondents were able to make an appointment or speak to someone when they last called the practice and 86% felt the last appointment they made was convenient in keeping with the CCG average. However, 37% of respondents reported waiting over 15 minutes from their appointment time which was above the CCG average.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system including the practice leaflet, practice complaints and comments leaflet and on the practice website. Patients were asked to make complaints formally in writing and these would be acknowledged within 3 working days and a written response issued in line with NHS policy. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 13 complaints received in the last 12 months and found they had all been managed in a timely manner in accordance with the complaints policy. We saw that complaints were a standing agenda item at the monthly practice meeting. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a patient charter leaflet that set out a clear vision to offer the highest standards of health care and advice. The patient charter set out the guidelines and standards the practice should achieve to deliver this vision. These included treating all patients with courtesy and respect, aiming to answer the reception phone within six rings and 80% of patients seen within twenty minutes.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available on the shared drive. We looked at seven of these policies and procedures and all had been reviewed annually and were up to date. These included, safeguarding policies, appraisal procedures and health and safety protocols.

There was a clear leadership structure and staff we spoke with 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. The QOF data for this practice showed it was performing in line with national standards. They took part in Clinical Commissioning Group (CCG) led local peer review, for example of antibiotic prescribing, unplanned hospital admission, referral rates and accident and emergency attendances, to measure the service against others and identify areas for improvement. The practice had an on-going programme linked to QOF and CCG schemes to monitor quality and drive improvements.

The practice had arrangements for identifying, recording and managing risks. Significant incidents were recorded and reviewed to identify learning points and actions to improve patient safety.

The practice held monthly practice team meetings where governance issues were discussed. We looked at minutes from the last six meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

The practice administrator and one of the GP partners were responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy, induction policy and appraisal policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, complaints received, a suggestion box in reception and from the patient participation group. The practice showed evidence they listened to and acted on feedback received from patients. For example, feedback left in the suggestion box from a patient about appointment waiting times to see one of the GP's, led the practice to adding additional catch up slots for that GP to reduce waiting times.

The practice had an active patient participation group (PPG) of 12 to 15 members. They met every two months and carried out regular patient surveys. We reviewed the survey report for 2013 – 2014 and saw the main points were summarised with action plans from the practice to act upon the feedback. For example, some patients requested a change to the '0844' contact number for the practice to a local area number and this was planned to be in place by 2015.

The practice had gathered feedback from staff through regular practice meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Clinical and administration staff received annual appraisal that included a personal development

Are services well-led?

Good

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

and training plan. Staff told us that the practice was supportive of training and there were study leave funds available for staff to use on training courses, for example recently some staff had attended phlebotomy courses and nurse prescribing courses.

The practice had completed reviews of significant events and other incidents which were shared with staff at team meetings and away days, to ensure the practice improved outcomes for patients. All complaints received were reviewed and discussed at the practice meetings to identify learning points and disseminate these to all staff.