# Dr Ruth O'Hare also known as The Connaught Square Practice

**Quality Report**

41 Connaught Square
London
W2 2HL
Tel: 0207 402 4026
Website: www.connaughtsquarepractice.co.uk

Date of inspection visit: 5 May 2015
Date of publication: 10/09/2015

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 Dr Ruth O'Hare also known as The Connaught Square Practice on 5 May 2015.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well- led services. It was 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:

- There were processes in place to report and discuss significant events and incidents and staff understood and fulfilled their responsibilities to raise concerns.
- There were processes in place to safeguard vulnerable adults and children.
- Patients' needs were assessed and care was delivered following best practice guidance.
- Patients said they were treated with kindness, dignity and respect and were involved in decisions about their care.
- Patients were generally satisfied with the appointment system and found it easy to make an appointment.
- Staff felt supported by the practice management and they were encouraged to maintain their clinical professional development through training.
- The practice demonstrated evidence of listening to patient feedback and made improvements to service as a result of this.

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

The provider should:

- Document learning points and action plans to improve future practice for all significant events recorded and discussed.
- Document learning points and action plans to improve future practice for all complaints recorded and discussed.
- Ensure that infection control audits are completed in line with best practice guidance.

# Summary of findings

- Ensure newly appointed staff completes role appropriate training in basic life support and safe guarding vulnerable adults and children.
- Ensure that annual appraisals are completed for all administration and nursing staff to support their professional development.

**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. Significant events were discussed at clinical meetings to share learning. There was a GP lead for safeguarding and the practice maintained a record of active safeguarding cases including who was responsible for completing outstanding actions. The practice had a recruitment policy that was followed and they regularly reviewed staffing levels to keep patients safe. The practice had equipment and medicines to manage medical emergencies and all clinical staff had received basic life support training. At the time of our inspection the practice could not evidence that regular infection control audits had been conducted. However, there was evidence that an infection control risk assessment had been completed and following the inspection an infection control audit was carried out by an external body.

**Are services effective?**

Good

The practice is rated as good for providing effective services. 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, including assessing mental capacity. The practice conducted regular clinical audit to monitor service and drive improvement. GPs were up to date with annual appraisal and required professional development. Nursing and administration staff had not received annual appraisal, however there was a program in place for this to begin in May 2015. The practice held regular multi-disciplinary team meetings to discuss and manage the needs of patients with complex medical needs. The practice had systems in place to promote the health of their patient population including offering NHS health checks and a full range immunisations in line with national guidance. There was evidence clinical staff used routine appointments to offer health promotion advice, such as screening for anxiety and depression with onward referral to in-house psychotherapy services if required.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Patients we spoke with described practice staff as friendly pleasant and caring and said that they involved them in decisions about their care. Completed Care Quality Commission (CQC) comment cards we received referred to staff as friendly, supportive, respectful and

# Summary of findings

caring. This was also reflected in patient satisfaction scores from the National GP patient survey published in January 2015. Information to help patients understand the services available was accessible and easy to understand. Interpreting services could be arranged and there were members of staff that could speak other languages to assist patients who did not have English as their first language.

**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 NHS England and the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients were satisfied with the appointment system and had access to same day urgent appointments if required. Results from the national GP patient survey showed higher than CCG average satisfaction scores with practice opening times and ease of getting through to the surgery on the telephone. However, some patients reported long waiting times to get a routine appointment with a named GP and this was also reflected in the national GP patient survey. The practice had good facilities and was well equipped to treat patients and meet their needs. There was no lift access to the upstairs floors for patients who could not manage stairs, however we were told by staff that they aimed to accommodate these patients by only offering them appointments in rooms on the ground floor. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

**Are services well-led?**

Good

The practice is rated as good for being well-led. The practice visions and values were displayed on the practice website and staff were aware of them. There was a clear leadership structure and staff felt supported and valued by management. The practice had a number of policies and procedures to govern activity and governance issues including performance, risk and quality, were discussed at regular clinical and administration meetings. The practice sought feedback from patients through patient surveys, comments left in the suggestion box and complaints. Staff had the opportunity to provide feedback at regular staff meetings and they told us they felt encouraged to do so. The patient participation group (PPG) was active and representative of the practice population. They held quarterly meetings and there was the option for patients to join an online PPG group to receive updates and make suggestions via email if they were unable to attend meetings.

# 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. All patients over the age of 75 years had a named GP and were given priority when booking appointments with them. They had access to urgent same day telephone consultations for medical advice. Home visits were available for patients unable to attend the practice due to illness or immobility. The practice offered routine screening for dementia to all patients over 75 years with referral on to local memory services if required. The practice offered flu and shingles immunisations to older patients in line with national guidance and these could be administered at home if patients could not attend the practice. The practice held regular multi-disciplinary team meetings to discuss the needs of older patients with complex medical needs.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. There were nurse led chronic disease management clinics for review and monitoring of people with long term conditions. The practice held regular multi-disciplinary team meetings to discuss and plan management of patients with complex medical needs. The practice were in the process of identifying patients with long term conditions at high risk of hospital admission and inviting them for review to create comprehensive care plans. A primary care navigator worked with practice staff to proactively find and co-ordinate health, social care and volunteer services to people with long term conditions. There was comprehensive health information on the practice website about common long term conditions, such as asthma, heart disease and diabetes, and this included information about relevant support groups.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. Families with children under five were given priority for urgent same day appointments. The practice offered post natal services including GP led six week mother and baby reviews. The practice offered a full range of childhood immunisations in line with national guidelines. There was comprehensive health information for pregnant women and families with children, on the practice website. The practice offered nurse led family planning and cervical smear clinics. Chlamydia screening was offered to patients aged 18 to 25 years.

# Summary of findings

**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). They offered daily extended hour appointments and weekend walk-in clinics for patients who could not attend the practice during normal working hours. Telephone consultations were also available and repeat prescriptions and appointments could be requested online. The practice offered NHS Health Checks for patient aged 40 to 74 years of age and these were well advertised in the waiting room.

**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 list of 12 patients with learning disabilities and invited them for annual review of care plans. There was an in house psychotherapy service available Monday to Friday to see patients with alcohol or drug misuse problems. Patients could self-refer to this service. There was a separate dedicated practice in Westminster that managed the medical needs of homeless patients in the area and as a result the practice did not have many on their list. Patients with no fixed address were offered immediate registration to allow them to access medical care when required.

**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). They offered routine screening for dementia to all patients over 75 years with referral on to local memory services if required. There was an in house psychotherapy service available Monday to Friday to see patients with anxiety or depression. Patients could self-refer to this service. There was a system in place to follow up on patients experiencing poor mental health who did not attend for practice and secondary care appointments.

# Summary of findings

## What people who use the service say

During our inspection we received 17 Care Quality Commission (CQC) comment cards that patients had completed and spoke with 16 patients. The majority of patients were satisfied with the care they received and felt that all staff at the practice were helpful, respectful and caring. This was similar to the findings of the national GP patient survey published in January 2015 which found that 80% of respondents described their overall experience of the practice as good and 68% said that they would recommend the practice to someone new to the surgery.

Some of the patients we spoke with told us they could wait a long time to get a routine appointment with a preferred doctor and not all were satisfied with the appointment system and this issue was also raised in some of the CQC comment cards we received. Results from the national GP patient survey showed that 71% of respondents described their experience of making an appointment as good. However, only 43% with a preferred GP were able to see or speak to that GP, which is below the Clinical Commissioning Group (CCG) average of 58%.

## Areas for improvement

**Action the service SHOULD take to improve**

- Document learning points and action plans to improve future practice for all significant events recorded and discussed.
- Document learning points and action plans to improve future practice for all complaints recorded and discussed.
- Ensure that infection control audits are completed in line with best practice guidance.
- Ensure newly appointed staff complete role appropriate training in basic life support and safe guarding vulnerable adults and children.
- Ensure that annual appraisals are completed for all administration and nursing staff to support their professional development.

# Dr Ruth O'Hare also known as The Connaught Square 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, practice manager and expert by experience who were granted the same authority to enter the practice premises as the CQC inspector.

## Background to Dr Ruth O'Hare also known as The Connaught Square Practice

Dr Ruth O'Hare practice is a well-established GP practice within the London Borough of City of Westminster and is part of the NHS Central London Clinical Commissioning Group (CCG) which is made up of 35 GP practices. The practice provides primary medical services through a Personal Medical Services (PMS) contract and also offers enhanced services which include extended hours. There are approximately 7,400 patients registered at the practice which has a high patient turnover due to transience within the patient population. There has been a recent rapid rise in the patient list size due to the closure of two GP practices in the area.

The practice team comprises of one female GP partner, one male GP partner, three regular male GP contractors, one female nurse, two female healthcare assistants, one male phlebotomist, a psychotherapist, family therapist, a practice manager and deputy who are supported by a secretary, three administrators and four reception staff. There has recently been a high turnover of administration staff due to maternity, long term sickness and resignation. The current practice manager has been in post for four months and the practice nurse for six months.

The practice opening hours are 8.00 am to 8.00 pm Mondays to Fridays (extended hours) and is closed between 12.30 pm to 1.30 pm on Thursdays for a lunchtime meeting. The practice provides services on Saturdays and Sundays between 10.00 am and 6.00 pm and patients can see a GP or nurse either by booking a same day appointment or by walking in. Patients do not have to be registered with the practice to access the weekend service. Out of hours services are provided by a local provider. The details of the out of hours service are communicated in a recorded message accessed by calling the practice when it is closed and on the practice website.

The practice provides a wide range of services including chronic disease management, child health care, specialist psychotherapy services and travel immunisations. The practice also provides health promotion services including a flu vaccination programme, smoking cessation service and cervical screening.

The age range of patients is predominately 25-54 years and the number of 25-39 year olds is greater than the England

average. There is a wide distribution of ethnic backgrounds in the practice patient population and 6% of registered patients speak Arabic only and many have Arabic as their first language.

The practice has previously been inspected in August 2014 and shortfalls were found relating to the arrangements in place for the completion of patient records.

## Why we carried out this inspection

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

The practice had previously been inspected by the Care Quality Commission on 18 August 2014. This was not part of the CQC's new methodology and as a result the practice did not receive a rating. They were in breach of Regulation 9 (1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 so we have re-inspected this location to check that improvements have been made and to give the practice a rating for the services they provide.

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.

## 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 Westminster 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 5 May 2015.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, community matron, reception manager, reception and administration staff. We also spoke with sixteen patients who used the service. 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 the procedure to report significant events and understood their responsibilities to raise concerns. For example a recent referral incident had been recorded and discussed with the local hospital A&E department to raise concerns and to prevent the same issue occurring in the future.

We reviewed safety records, incident reports and minutes of meetings where these had been discussed in the last eight months. This showed the practice had managed these consistently over this time period.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last eight months and we were able to review these. Significant events and clinical incidents were a standing item on the weekly clinical multi-disciplinary meeting agenda. Records demonstrated that individual cases were discussed and outcomes concurrently documented into the relevant patient case record. Staff we spoke with knew the procedure to follow to raise a significant event or issue.

Staff used incident forms on the practice intranet and completed forms were processed by the practice manager. We tracked eight incidents and saw records were completed in a timely manner. We saw the outcome of incidents had been recorded, however there was no documentation of learning points and action plans to improve future practice.

National patient safety alerts were disseminated by the practice manager to practice staff via email. Staff we spoke with were able to give examples of recent alerts, for example a controlled drug alert and medical update on Ebola virus. They also told us alerts were discussed at regular practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all clinical staff had received relevant role specific training on safeguarding, for example all GPs, nurses and health care assistants (HCA) had received level three child protection training. All administration staff had undertaken safeguarding training with the exception of newly appointed staff members who had yet to complete the on-line course. The staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns. Anonymised patient records reviewed confirmed safeguarding concerns were managed appropriately and according to procedure.

The practice principal GP was the dedicated lead in safeguarding vulnerable adults and children. All staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern.

The practice maintained a list of patients with safeguarding concerns that included any actions required and the outcomes of case reviews. Safeguarding cases were discussed at the weekly clinical meetings to ensure staff were aware of any issues. The outcomes of safeguarding concerns were documented in the patient's electronic records.

There was a chaperone policy, which was visibly displayed around the practice. (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). Administrative staff would act as a chaperone if nursing staff were not available, reception staff were not required to undertake this duty. All staff with chaperone duties had a criminal record check by the Disclosure and Barring Service (DBS) and had completed chaperone training.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators 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 there had been no recent incidents

documented when the refrigerator temperatures had been out of range. The practice had experienced a recent unexpected electrical power outage for a two hour period and we were informed that appropriate actions had been taken to assure that the cold chain had been maintained.

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.

The practice nurse 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 assistants administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescribing GP. The nurse and health care assistants had received training to administer vaccines and medicines. There was a system in place for the management of high-risk medicines, for example INR monitoring was offered for patients prescribed warfarin and appropriate actions were taken based on the results.

The practice had a repeat prescription protocol and all 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 saw there were cleaning schedules in place and up to date 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.

The practice had a nominated lead for infection control. At the time of our inspection the practice could not demonstrate that staff had undertaken recent infection control training and could not evidence that regular infection control audits had been conducted. There was evidence that an infection control risk assessment had been completed by the recently appointed practice manager. Following the inspection the practice provided us with a report and action plan from an infection prevention audit carried out by an external body 8 June 2015. We saw that some of the required actions had already been completed and that time scales had been agreed for those that remained outstanding. For example, all staff had now completed infection control training and hand washing sinks were to be replaced within a year.

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 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 a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed across the practice. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

At the time of our inspection the practice could not demonstrate that a legionella (a bacterium that can grow in contaminated water and can be potentially fatal) assessment had been undertaken. After the inspection the practice made arrangements for a legionella assessment and we saw confirmation that this had been undertaken with a clear result.

### Equipment

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometer.

### Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) when this check was required.

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

enough staff were on duty. The practice had an induction plan of training for new staff joining the practice. There was also an information sheet for locum doctors that work at the practice to provide them with information about the running of the surgery and they were required to sign a form to confirm they had read and understood this information.

The practice manager told us they assess the skill mix and needs of the practice. They used information on appointments, waiting times and workload to make decisions on staffing levels. We were told they were currently advertising for additional GP staff.

### 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 annual, bi-annual, quarterly and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw that a comprehensive health and safety risk assessment had been undertaken including control of substances hazardous to health (COSSH) in March 2015 and infection control risk assessment in February 2015.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical staff had received training in basic life support, but newly appointed administration staff had yet to complete this. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The staff we spoke with 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 staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia, infection and chest pain. Processes were also in place to check on a monthly basis whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice had algorithms and protocol for staff to follow in the event of medical emergencies, for example adult basic life support, paediatric life support, choking and anaphylactic reactions.

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 loss of the surgery building, computer system, utilities alarm systems and incapacity of staff. It also provided relevant contact details for staff to refer to.

The practice carried out weekly checks of the fire alarm system and practiced regular fire drills. The fire alarm system was serviced every three months. Records showed that most staff were up to date with fire safety training, although one member of the reception staff told us they had not completed fire safety training yet but that it was planned.

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 Clinical Commissioning Group (CCG). We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, at a recent clinical meeting one of the GPs had presented a case study on high blood pressure and then discussed new NICE guidelines on managing the condition. Copies of this presentation was distributed to clinical staff including those who could not attend the meeting to share learning. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they had interests in specialist areas such as community cardiology and one of the GPs was the respiratory lead for the CCG. The practice nurses supported this work, 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.

The senior GP partner showed us data from the local CCG of the practice's accident and emergency attendances, which was comparable to similar practices. We were told there was a system in place to invite patients who were frequent attenders to the weekend walk-in service for review to identify if their needs could be met by the practice in hours. There was a system to identify patients at high risk of hospital admission and these patients were invited for review to discuss care plans.

All the GPs we spoke with used national standards for the referral, for example all patients with suspected cancer were referred and seen within two weeks. All two week referrals were monitored to ensure that patients had been seen. Regular audits of elective and urgent referrals were conducted by one of the GP partners to assess appropriateness.

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

### Management, monitoring and improving outcomes for people

The practice showed us three clinical audits that had been undertaken in the last year. For example, the practice had noted prescribing rates of opiate and hypnotic medicines were high and conducted an audit to review this. They found some patients had been receiving these medicines on repeats without review and some were receiving combinations of these medicines that could cause side effects. As a result, the GP involved discussed the findings in the practice clinical meeting to raise awareness of the issue and made recommendations to review those patients on repeat prescriptions for these medicines. The second cycle of this audit was in process at the time of the inspection.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or 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). For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs and an audit on antibiotic prescribing that were linked to the prescribing incentive scheme.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in cancer, dementia, heart failure and palliative care and the majority of the standards in atrial fibrillation, stroke and depression. It was noted not all the minimum standards for QOF had been achieved for diabetes and high blood pressure, though the practice manager told us they used QOF data to drive improvements at the practice in these areas, for example by arranging staff training in diabetic foot reviews.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly

Good

# Are services effective?

(for example, treatment is effective)

checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice had a palliative care register and had regular meetings with the community palliative care nursing team to discuss the care and support needs of patients and their families.

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 to other services in the area. For example, accident and emergency (A&E) attendances were in line with the CCG average. We were told by the principal GP that the rate of A&E attendances had reduced since the practice had opened the weekend walk-in clinic.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all clinical staff were up to date with attending mandatory courses such as annual basic life support. We noted that several newly appointed administration staff had yet to complete the mandatory training course programme although we were told that plans were in place. 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).

The practice had not conducted recent annual appraisals for the nursing or administration staff, however the practice manager who was new to the post had developed a new procedure for appraisals and told us this would be rolled out during May 2015. They told us this procedure included self-assessment forms completed online and peer assessment which would be reviewed at annual appraisal and used to direct completion of personal development plans.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology and wound care. Training on chronic disease management for nursing staff was offered in house by the principal GP.

At the time of our inspection we were informed that a medical practitioner trained abroad and employed by the practice as a health care assistant (HCA) was being trained to take samples for the cervical screening programme. We had concerns as this type of screening test must only be carried out by a qualified nurse or doctor with licence to practice in the UK. However we have since been informed that sample taking will only be undertaken by the practice nurse.

### 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 procedure for reading and acting on any issues arising from communications with other care providers on the day they were received. The administration team reviewed received faxes and mail and passed on urgent communications to the duty doctor who actioned them as required. Non urgent communications were left in the relevant GPs inbox tray for review and those letters or faxes that did not require any action were summarised and scanned into the patient's electronic records.

The practice held multidisciplinary team meetings weekly to discuss the needs of complex patients, for example those with end of life care needs, complex conditions or children on the at risk register. These meetings were attended by clinical staff at the practice, district nurses, palliative care nursing team, social services and the primary care navigator. Decisions about care planning were documented in a shared care record during the meeting.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system for sharing some patient's notes with the out of hours provider electronically if required. Electronic systems were also in place for making referrals, and the practice made 80% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date

Good

# Are services effective?

## (for example, treatment is effective)

and time for their first outpatient appointment in a hospital). GPs told us they used referral templates to ensure all relevant information was completed for each patient including information on interpreter requirements.

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 co-ordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. During our previous inspection at the practice on 18 August 2014 we found shortfalls with the completeness of patient records. At this inspection we saw evidence that spot check audits had been carried out to assess completeness of patient records and that action had been taken if any shortcomings were identified.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it), The practice kept records and demonstrated that 42% of care plans had been reviewed.

There was a practice policy for documenting consent for intimate examinations in the patient's electronic records along with when a chaperone had been offered. The practice did not perform minor surgical procedures.

### Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. All patients were asked to complete a registration form that included details on medical problems, lifestyle choices such as smoking and alcohol and whether the patient was a carer. These forms were reviewed at new patient heath checks and the GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years, smoking cessation advice to smokers, screening for anxiety and depression and referral to in house psychotherapy service if appropriate.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years and these were advertised with leaflets and posters in the waiting room. We were told if patients had risk factors for disease identified at the health check they would be followed up and scheduled further investigations if required.

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 they were offered an annual physical health check. The practice had also identified the smoking status of 79% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

The practice's performance for cervical smear uptake in 2013 - 2014 was 72% which was low compared to the national average. The practice told us the low uptake rates were due to the transient nature of the practice population. There was a policy to offer letter and text reminders for patients who did not attend for cervical smear screening and reminders were also included on patients prescriptions.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The uptake rate for childhood immunisations last year was 59% - 82% at 12 months, 73% - 86% at 24 months and 62% - 83% at five years depending on vaccination. The uptake rate for flu immunisation in patients over 65 years of age was 61% and 34% in high risk patients under 65 years.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

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

Evidence from the latest GP national patient survey published by NHS England January 2015 with a completion rate of 23% (98 respondents of 426) showed that patients were satisfied with how they were treated. Seventy-two per cent said that the last GP they saw or spoke to was good at treating them with care and concern and 88% found the receptionists at the surgery helpful. Eighty-eight per cent of respondents said the last nurse they saw or spoke to were good at treating them with care and concern and 87% said the last nurse they saw was good at listening to them.

The practice had a chaperone policy and information about chaperoning was displayed in consulting rooms. 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. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The waiting room was separated by a door from the reception area so conversations at reception could not be overheard. However, the reception area was small and it would be possible to overhear conversations if there were many patients waiting in line to speak to reception. We observed there was no available space if patients wished to discuss something in private away from the reception or waiting room and this was also mentioned by one of the patients we spoke with.

### 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, 77% of respondents said the last GP they saw was good at listening to them and 72% felt the GP was good at explaining tests and treatments. Seventy-nine per cent of respondents said the last nurse they saw was good at involving them in decisions about their care and 87% said the last nurse they saw was good at giving them enough time.

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received. They also told us the GPs explained results and treatment options well and provided sufficient information for them to make informed decisions about their care. Patient feedback on CQC comment cards we received reflected this feedback.

The practice had a number of Arabic speaking patients and had adapted services to ensure these patients could be involved in their care. One of the GPs spoke Arabic and there was also the option to book an interpreter 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 and CQC comment cards we received reflected this feedback. Information in the waiting room sign-posted patients to a number of support groups and organisations for people experiencing anxiety and for isolated older people.

The practice registration form documented if a patient was a carer and this was recorded in their electronic records. A register of patients who were carers was maintained and one of the administration staff was a 'carers champion' whose role was to improve the identification of carers and to provide information about service provision available to carers. Written information in both English and Arabic was

Good

# Are services caring?

displayed across the practice to raise awareness of the support available to carers. The practice had plans to hold a day event for carers, with participation from external organisations.

Procedures were in place for staff to follow in the event of the death of one of their patients. This included informing other agencies and professionals who had been involved in the patient's care, so that any planned appointments, home visits or communication could be terminated in order to prevent any additional distress. Any patient deaths were discussed in weekly team meetings so that staff were all aware when a patient had died. Letters of condolence together with a card from the whole practice offering support were sent to bereaved relatives.

The practice maintained a list of patients receiving end of life care and if any patients had advanced directives or specific care plans in place these were made available to the out of hours provider via the 'Co-ordinate My Care' scheme. The practice had close links with the palliative care nursing team and held regular meetings with them.

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.

NHS England and the 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 principal GP was the CCG chair and would feedback to the practice information and updates from the regular meetings attended.

All patients over the age of 75 years had a named GP and practice staff told us that they gave priority appointments to these patients. Patients over the age of 75 years were also given access to same day emergency telephone consultations for medical advice or to arrange urgent review. Home visits were available for patients unable to attend the practice due to illness or immobility and this included administration of flu vaccinations at home if required. The practice offered flu and shingles immunisations for older patients in line with national guidelines and these were well advertised in the practice waiting room. The practice held regular multi-disciplinary team meetings to discuss and plan management of patients with complex medical needs.

The practice offered chronic disease management nurse led clinics for regular review of patients with long term conditions. There was comprehensive health information on the practice website about common long term conditions, such as asthma, heart disease and diabetes, and this included information on relevant support groups. We were told by the practice manager that the practice had used recent Quality Outcome Framework (QOF) data on long-term conditions to identify areas to focus improvements to service. For example, the practice had not achieved all the QOF minimum standards for diabetes and were planning training in diabetic foot review for health care assistants.

The practice was in the process of developing a list of vulnerable patients at high risk of hospital admission, for example frail older people and those with long term conditions, to invite them to review and plan care plans. A primary care navigator worked with practice staff to proactively find and co-ordinate health, social care and volunteer services to patients with support need.

The practice had held a special educational session on diabetes which was conducted by an Arabic speaking GP from the practice in February 2015. Arabic patients with a diagnosis of diabetes were personally invited to attend the seminar. We were told that 10 diabetic patients attended and as a result had developed a good understanding of the impact of diabetes and the importance of annual review including what is assessed and the reasons why.

The practice told us they gave priority appointments to families with children under five years old who needed urgent medical review. The practice offered routine 6 week baby and mother checks as part of the postnatal service. There was comprehensive information on the practice about health issues for families ranging from pre-pregnancy care, health during pregnancy and child health. The practice offered the full range of childhood immunisations in line with national guidance. Nurse-led family planning and cervical smear clinics were available for women.

The practice offered extended hour appointments daily that were useful for patients in full time work or education and could not access the practice during the working day. The practice also offered a weekend walk-in service. Repeat prescriptions and appointments could be made online for those patients unable to attend the practice in person. Telephone consultations were also available daily for patients to receive medical advice if appropriate over the phone. The practice offered NHS Health Checks for patient aged 40 to 74 years of age and these were well advertised in the waiting room.

The practice maintained a list of 12 patients with learning disabilities and invited them for annual review of care plans five of which had been completed. There was a separate dedicated practice in Westminster that managed the medical needs of homeless patients in the area and as a result the practice did not have many on their list. One of the GPs told us they had seen one patient with no fixed address in the last year and in this case they were registered at the practice immediately to have access to medical care.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice used a screening tool for all patients over the age of 75 years to identify those who may be suffering from undiagnosed dementia. These patients were referred on to the local memory services. The practice maintained a register of patients with dementia and had 25 patients on this list identified with the screening tool. Review of anonymised patient records confirmed the practice was using the screening tool for dementia and results were recorded appropriately in the patient's medical notes. The practice employed an in house psychotherapist and a family therapist who were available to see patients Monday to Friday with a variety of issues such as anxiety, depression, bereavement and alcohol or drug misuse problems. They also accepted referrals for patients from other practices. There was a system in place to follow up any patients experiencing poor mental health who did not attend appointments at the practice or secondary care.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice had received feedback that the wait for routine appointments was long and as a result the practice conducted regular audits of waiting times to allow restructuring of the daily appointment schedule to increase the number of routine appointments when required.

### Tackling inequity and promoting equality

The practice had access to a service to book interpreters for those who did not speak English as their first language and one of the GPs also spoke Arabic as a second language. Those patients who required an interpreter would be given double appointments. The practice was trialling a label translation scheme that involved translating medicine labels into Arabic to assist patients where this maybe of benefit. The practice website was also in the process of being updated to include a facility to translate English text to Arabic. There was a hearing loop facility for patients with hearing impairment.

The practice manager told us there was a ramp available to assist wheelchair users when entering the premises. The practice was situated on the first and second floors of the building but there was no lift access to the upstairs. Staff told us they would ensure patients with difficulty using stairs only had appointments in consulting rooms on the ground floor. There was a notice in the waiting room advising patients to alert the reception staff if they could not manage stairs so appointments could be made for rooms on the ground floor. The only patient toilet facilities available were situated on the first floor and therefore not accessible for patients who could not manage stairs. The waiting area had limited space to accommodate prams and wheelchairs.

### Access to the service

Appointments were available from 8.00 am to 8.00 pm weekdays and from 10.00 am to 6.00 pm Saturdays and Sundays. Walk-in appointments for acute medical conditions were available from 8.00 am to 11.00 am Mondays to Fridays, with same day appointments and telephone consultations bookable through reception. Routine appointments with a preferred GPs could be booked in advance, though we were told by staff the wait for these could be up to 3 to 4 weeks depending on the GP. Home visits were available for patients unable to attend the practice due to illness or immobility. Walk-in appointments for emergencies were available on Saturdays and Sundays.

Comprehensive information was available to patients about appointments on the practice website and 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. 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.

Longer appointments were also available for patients who needed them, for example if an interpreter was required or if it was an appointment to discuss care plans.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Feedback from the National GP patient survey published in January 2015 showed patients were happy with access to the practice as 89% of respondents were

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

satisfied with the practice opening hours and 91% found it easy to get through to the surgery on the phone. Both of these results were above the average scores for the CCG area.

Many of the patients we spoke to mentioned there could be a long wait to get an appointment with a preferred GP. This was also reflected in the GP survey results with only 43% of respondents with a preferred GP were able to see or speak to that GP and this score was below average for the CCG area. The practice staff told us they were aware of the issues with waiting times for routine appointments with preferred GPs and were planning to recruit additional GP staff with the aim to reduce this time.

The practice's extended opening hours on until 8pm on Mondays to Fridays and Saturday and Sundays from 10am to 6pm were particularly useful to patients with work commitments.

### 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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system on the practice website and in the waiting room in the form of a complaints leaflet and also on a poster on the notice board. 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 20 complaints received in the last 12 months and found they were dealt with in a timely manner according to the complaints policy. A log of all complaints received was kept on the electronic system with information about the complaint, outcome and when a response had been sent. We were told these were reviewed annually to identify themes and trends. However, we noted that learning points and action plans to improve service as a result of the complaint were not documented.

# 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 vision to deliver high quality care and innovative primary care services to the patient community. We found details of the practice vision and values on the practice website. The practice vision and values included to work in partnership with patients to achieve the best quality care and to involve patients and listen to their thoughts and opinions in all aspects of medical care.

Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at four of these policies and procedures, including recruitment policy, safeguarding procedures and infection control. All policies and procedures had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the principal GP was the lead for safeguarding. 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 for most areas. The practice manager told us they had used the QOF data to identify areas where improvement was needed, for example diabetic checks, and would be focusing on these areas in the coming year.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a recent audit had been conducted into repeat prescriptions of opioid and hypnotic medicines that had found prescription rates were high and with these results raised awareness of the issue to the clinical team in an effort to reduce such prescriptions.

The practice held weekly clinical and administration meetings and minutes confirmed governance issues were discussed, including performance, quality and risks.

### Leadership, openness and transparency

We saw from minutes that clinical and administration meetings were held regularly. 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.

The practice manager was new in post and they told us they were working towards a more focused direction and clear leadership for the practice. The practice manager was responsible for human resource policies and procedures which were in place to support staff, for example recruitment policy, induction procedure and appraisal guidance. They had arranged access to an external company portal where staff could log in to book annual leave and record sickness. 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 comments in the suggestion box, the Friends and Family Test, GP annual patient surveys and complaints received. We looked at the results of the GP annual patient survey 2013 and 56% of respondents felt appointments on the weekends would be beneficial. This data was taken into consideration when the practice took on extended weekday and weekend opening hours. Results showed 85% of respondents to this survey said they would recommend the practice to someone who has just moved to the area.

The practice had an active patient participation group (PPG) that included representatives from all age groups and variety ethnicities and met every three months. There was also an online PPG where updates and suggestions could be received by email for patients who were unable to attend the meetings but still wished to be involved. We were told that in an effort to increase opportunities for PPG member attendance at meetings the practice had plans to schedule the meetings at different times of the day.

The practice had gathered feedback from staff through regular clinical and administration staff meetings. Staff told

# Are services well-led?

Good

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

us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved in the practice to improve outcomes for patients.

The practice had a whistleblowing policy which was available to all staff 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. The practice GPs were all up to date with their annual appraisal and continued professional development. Appraisals had not been conducted for nursing and administration staff to date, however the practice manager told us this was an area for improvement and they had arranged a program of annual appraisal to start in May 2015. These appraisals would include self-assessment of performance and manager feedback forms. Staff told us that the practice was supportive of training and that they had access to training when required.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, a recent significant event was discussed when concerns had been raised that a patient had been making too frequent repeat prescription requests for potentially harmful medication. The case was discussed and an alert put on the record that no further prescriptions should be issued until the patient had attended for review. The case was used to illustrate the importance of regular review of repeat prescriptions.