Brook Green Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Brook Green Medical Centre provides NHS primary care services to patients in the Hammersmith area of West London. The practice currently has approximately 12,400 patients on its list. We carried out an announced comprehensive inspection of the service on 1 October 2014.

We rated the practice as Good overall for the quality of its services. The practice was rated as Good for the effectiveness of its service, Good for being caring and as Good for being well-led. We rated the service as Requires Improvement for aspects of safety and as Outstanding for being responsive to the needs of its patients.

Our key findings were as follows:

- The practice had systems in place to manage risks associated with medicines management, staff recruitment, infection control, child protection and medical emergencies. However, not all staff were trained on adult safeguarding and some staff who were occasionally called upon to act as chaperones were unclear about the role.
- The practice understood the needs of the population and had developed the service and skills of the staff team to meet patients' needs. We found that care for some long term conditions such as mental health and diabetes was being managed effectively in the community and was provided in partnership with other specialist services.
- Patient satisfaction scores were in line with local and national averages for the quality of care and better than average for access to appointments. Patients we spoke with were very positive about the practice and described it as excellent.
- The practice had worked hard to ensure that the patient reference group was representative in terms of ethnic diversity, age and employment status, for example, recruiting patients from a nursing home and trying to engage patients in vulnerable groups.

We saw several areas of outstanding practice including:

Summary of findings

- The practice proactively engaged with a local homeless charity to provide care to homeless people who were not engaging with health or other formal services.
- The practice provided outstanding care for people with mental health problems, for example offering joint assessment with the psychiatric liaison worker. Staff members were carrying out research on personality disorder in primary care.
- The practice was innovative in engaging patients with long term conditions for example running an open event and the use of a volunteer expert patient to support patients with diabetes. The volunteer regularly attended the practice to talk with patients with diabetes and signpost them to other useful resources in the community.
- The practice was open about sharing feedback with staff and patients, for example posting anonymised patient comments and concerns and the practice response in the waiting area.

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

The provider should:

- ensure that all staff undertaking chaperone duties should understand the role and how to carry it out effectively.
- ensure that GPs and practice staff receive training on recognising abuse of vulnerable adults
- obtain and document evidence in relation to new employees' previous employment record in line with the practice recruitment policy.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Reviews and investigations were thorough and lessons learned were communicated to support improvement. Risks to patients who used services were assessed and the practice had systems and processes to address risks in relation to infection control, medicines management and dealing with emergencies. However, the practice did not fully document the staff recruitment process and could not show us evidence that satisfactory references had been obtained before new members of staff started work at the practice. The practice had not ensured that all staff had been trained on safeguarding vulnerable adults and some staff who occasionally undertook chaperone duties were unclear how to carry out this role effectively.

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 NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice staff received annual appraisals including personal development planning. Staff worked with multidisciplinary teams.

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 compassion, 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.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been

Summary of findings

identified. The practice had initiated positive service improvements for its patients that were over and above its core contractual obligations for example, providing a weekly drop-in service to vulnerable patient groups in the community.

The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient reference group for example, reorganising the appointments system to enable better telephone response and access to same-day emergency appointments. The patient reference group was active and representative of the practice population.

Patients told us they could get an appointment when they needed one. The practice also scored well on access to appointments in the 2014 National GP Patient Survey. Information about how to complain was available and easy to understand, and the practice responded promptly when issues were raised. Learning from complaints and feedback was shared with staff and other stakeholders and also displayed in the waiting room.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and supported the GP partners to lead effectively. This was reflected in day to day practice and engagement with commissioners and providers. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. 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 it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and away days.

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. Nationally reported data showed that outcomes for patients were good for health conditions commonly found in older people, for example chronic obstructive pulmonary disorder (COPD). The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice held a contract with a local residential care home for older people. The lead GP for older people visited the home on a weekly basis to review people's care or more frequently should a patient become unwell. All patients over 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients with complex long term conditions had a named GP and a structured annual review to check that their health needs were being met and review treatment and medicines. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice was innovative in engaging patients with long term conditions, for example, running an open evening event and using a volunteer 'expert patient' to support patients with diabetes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, with a high number of A&E attendances. The practice ran regular safeguarding meetings with health visitors and social care professionals to ensure that concerns were followed-up and referred appropriately.

Immunisation rates were relatively high for standard childhood immunisations at 24 months and five years. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

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). The practice had adjusted the services it offered to ensure these were accessible and flexible for people of working age. The practice was proactive in offering online services as well as a full range of health promotion and screening, reflecting the needs of this age group.

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 held a register of patients living in vulnerable circumstances including homeless people, people living with HIV and people with a history of substance misuse.

The practice had developed an association over many years with a charity supporting homeless people. The charity was located outside of the immediate catchment area but these people were often on the margins of society, with multiple health problems and finding it hard to access 'normal' GP services. The practice was contracted to offer weekly drop-in sessions at the centre.

In addition to providing GP consultations in the community, the practice encouraged and facilitated homeless patients' registration with the practice so they could receive better continuity of care (for example through preventative screening, management of long-term conditions, and co-ordination with other services). The receptionists were understanding of the difficulties some patients experienced in accessing the surgery and worked to remove any administrative barriers. For example if people had no fixed abode, the practice used the charity as their registered address for correspondence. The practice was able to demonstrate that they had registered patients who regularly used the service who previously did not have access to a GP.

The practice maintained a register of people with learning disabilities. One of the GPs took the lead for learning disabilities to provide continuity of care. People with learning disability received an annual health check. The practice provided joint consultations and assessments with the community learning disabilities nurse to ensure that patients' wider needs were addressed. The practice offered longer appointments for people with a learning disability or other complex needs.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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. Mental health had been identified as a local priority and two of the GPs had developed a special interest in this area undertaking extra training and qualifications. The GP trainees we spoke with said they were receiving high quality mentoring and support on mental health in primary care.

The practice worked with specialist mental health services to provide a holistic service, for example, offering patients with mental health problems consultations with their GP and the community psychiatric liaison worker together. The practice was successfully supporting the transfer of patients with mental health problems from specialist to ongoing primary care through an enhanced service. We were told this involved careful consultation with patients who were sometimes reluctant to make such a significant change. The practice had a number of patients who experienced multiple health and social problems, for example mental health problems exacerbated by alcohol and substance misuse and homelessness. Closer working between the practice and community mental health services as a result of the enhanced service had meant that patients had rapid access to specialist care and symptoms were being recognised earlier before patients experienced further deterioration or crisis.

The practice provided primary care to a number of patients with severe and enduring mental health problems and/or alcohol and substance misuse problems in a local supported housing scheme. The patients sometimes presented with challenges in particular around engagement with health and other supporting services. The practice had a dedicated GP who looked after these patients on a regular basis, encouraging an interest in their physical health as well support in engaging with alcohol and drug services. The practice also delivered a quarterly clinic at the home to work on engagement with medical services, coordination with health and social care services and to provide support and education to the staff.

Staff members had collaborated with colleagues in two other practices to undertake a piece of research into personality disorder in primary care and were preparing their findings for publication.

Summary of findings

What people who use the service say

The 2014 National GP Patient Survey results showed that patients were generally positive about the quality of care they received. The practice was performing in line with local area and national averages on a range of scores relating to quality of consultations with doctors and how well patients were involved in decisions about their care. The practice scored better than the local and national averages for questions on whether patients would recommend the service to others and how easy it was to access the service.

We spoke with 11 patients who used the service. The practice also displayed a notice about the inspection in the waiting area and provided feedback forms for patients to complete on the day of the inspection. We reviewed 12 of these completed feedback forms. The feedback was wholly positive about the practice with patients saying that the staff were caring, understanding and involved patients in treatment choices. We spoke with one patient who told us they had complex health needs and the practice had effectively coordinated their care with a number of other health and social care agencies.

The practice had arranged an open evening for people with diabetes and this had received positive feedback. The practice had plans to hold more of these sorts of events for patients.

The practice engaged patients through a representative patient reference group and conducted its own annual survey. The practice responded to patient comments posted to public websites about the service and displayed these comments together with their response in the waiting area.

Areas for improvement

Action the service SHOULD take to improve

All staff undertaking chaperone duties should understand the role and how to carry it out effectively.

The practice should ensure that staff training on safeguarding vulnerable adults is carried out in line with practice policy.

The practice should obtain and document evidence in relation to new employees' previous employment record in line with the practice recruitment policy.

Outstanding practice

- The practice proactively engaged with a local homeless charity to provide consultations to homeless men who had a history of not engaging with health services.
- The practice provided outstanding care for people with mental health problems, for example offering joint assessment with the psychiatric liaison worker and was carrying out research on personality disorder in primary care.
- The GP partners invested in leadership and management by reducing the clinical sessions of the executive lead GP (a role which was shared in turn by the GP partners)
- The practice was open about sharing feedback with staff and patients, for example posting anonymised patient comments and concerns and the practice response in the waiting area.
- The practice was innovative in engaging patients with long term conditions for example running an open evening event and the using of a volunteer "expert patient" to support patients with diabetes
- A volunteer "expert patient" regularly attended the practice to talk with patients with diabetes and signpost them to other useful resources in the community.

Brook Green Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector**.** The team included a GP, an "expert by experience" and a practice manager. All team members were granted the same authority to enter the practice premises as the CQC inspector.

Background to Brook Green Medical Centre

Brook Green Medical Centre is located in Hammersmith in West London. The practice provides NHS primary medical services through a General Medical Services contract to 12,400 patients in the local community. The practice has a larger than average proportion of adults in the 25-44 age range and is ethnically diverse. Income deprivation levels for the practice population are close to the English average.

The practice staff team is comprised of five GP partners, six salaried GPs, two practice nurses, two healthcare assistants, a practice manager and a team of reception and administrative staff. The practice is an NHS GP training practice and a number of GP trainees (registrars) also work and train in the practice at any one time. Both male and female doctors are available.

The practice was open most weekdays from 08:00 until 20:00; from 07:00 until 20:00 on Wednesday and Thursday and also on Saturday mornings. Walk-in appointments and telephone consultations for urgent health problems were available from 09:00 until 17:00 every weekday. The practice had opted out of providing out-of-hours care and signposted patients to local out-of-hours primary care and emergency services.

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. This provider had not been inspected before and that was why we included them.

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

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked the Clinical Commissioning Group, the NHS England Local Area Team for Hammersmith and Fulham and the local Healthwatch to share what they knew. We carried out an announced visit on 1 October 2014. During our visit we spoke with a range of staff including four GP partners, a sessional GP, a GP trainee, a practice nurse, the practice manager, a health care assistant and three administrative staff. We reviewed fifteen patient records. We spoke with 11 patients who used the service. The practice also displayed a notice about the inspection in the waiting area and feedback forms for patients to complete on the day of the inspection. We reviewed 12 of these completed feedback forms.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice analysed and monitored information to identify risks and improve patient safety. It had systems to monitor reported incidents, national patient safety alerts, and complaints received from patients. We saw an example, where the practice had responded to a recent reminder from Public Health England about the risks of Pertussis (whooping cough) by checking whether women attending for antenatal checks had previously had this vaccination. Women who were not protected were offered the vaccination as part of their antenatal care. The staff we spoke with were aware of their responsibility to raise concerns, and knew how to report incidents and near misses. The practice manager had recently reviewed and revised this documentation to facilitate progress monitoring and produce a monthly report on incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and we reviewed these for the previous year. Significant events were a standing item on the clinical team meeting agenda and a dedicated report was presented to the meeting to review actions from previous events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff and other agencies when appropriate. Staff, including receptionists, GP registrars, nursing staff and health care assistants, knew how to raise an issue for consideration at the meetings and they said they were encouraged to do so. For example, we reviewed an incident relating to an ultrasound scan. This had been documented and the findings shared with the acute trust. We asked several members of staff about the incident during the inspection and they consistently explained what had happened and the learning points.

Structured incident forms were available on the practice intranet and staff sent completed forms to the practice manager. We saw the system used to manage and monitor incidents and evidence of action taken as a result. For example, in one case involving a potential misdiagnosis the patient was recalled immediately for a further consultation.

National patient safety alerts were disseminated electronically to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in the regular clinical team meeting to ensure all clinical staff were aware of any that were relevant to the practice and where they needed to take action. The health care assistants did not attend these meetings. We were told that their attendance was under review at the time of the inspection.

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 staff had received relevant role specific training on child protection. Staff had not received formal training on recognising abuse in vulnerable adults. However, they understood their responsibilities to share information, properly document safeguarding concerns and how to contact the relevant agencies both in and out of working hours. The practice ran regular multidisciplinary team meetings to review safeguarding cases covering both children and vulnerable adults. Professionals from other agencies attended these meetings including health visitors and representatives from the local authority Early Intervention Team.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice nurse and health care assistants had been trained to be chaperones. The administrative staff we spoke with told us they occasionally acted as chaperones although this was becoming less frequent. These staff members were sometimes unclear about the role, for example the importance of being able to observe the examination.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The system was flexible and allowed a range of alerts to be added to the electronic records, for example, to highlight patients taking multiple medicines.

Requires improvement

Are services safe?

The practice offered minor surgery. The GP who led on surgical procedures had introduced a system to check and document the histology results for all specimens as a failsafe to ensure that any abnormalities would be picked up by the practice and followed up promptly.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

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. The practice followed set procedures to ensure that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data and significant events involving medicines. For example, following an incident involving an overdose, the practice reviewed its repeat prescribing policy to ensure that the number of repeat prescriptions issued before the patient had a review was fixed.

The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We reviewed

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. We checked the anonymised patient records of five patients with severe mental illness which confirmed that these procedures were being followed.

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 and stored securely.

Cleanliness and infection control

The premises were clean and tidy. Patients told us they had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection prevention and control and provided advice on the practice infection control policy and delivered staff training. All staff received training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an infection control audit within the last twelve months.

The practice had an infection control policy which had been reviewed in September 2014. This was comprehensive and covered for example, the disposal of sharps and the management of instruments, biological substances, waste management and hand washing. There was also a protocol for needle stick injury. The practice used single-use equipment wherever appropriate, for example only using single-use tips for minor surgery.

Personal protective equipment including disposable gloves was 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.

Notices about hand hygiene techniques were displayed in treatment rooms and the staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were also provided in the treatment rooms. The treatment room used for minor surgery was appropriately equipped with a designated clean area. The layout of this room had been organised to minimise the risk of cross-contamination.

The practice contracted with a cleaning company with set cleaning schedules and records of monthly, weekly and daily tasks. Cleaning was carried out in line with current national guidance, for example in relation to cleaning materials and equipment.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly in line with the manufacturers' instructions and we saw equipment maintenance logs and other records confirming this. For example the nebulisers and weighing scales were checked annually. The hyfrecator (a piece of equipment used in minor surgery) had previously been tested in December

Requires improvement

Are services safe?

2013 and was due to be retested in December 2015. We saw evidence that relevant equipment such as spirometers and blood pressure monitors had been calibrated (that is, checked to ensure that they gave readings that were accurate and reliable).

Staffing and recruitment

Records we looked at did not include evidence that all appropriate recruitment checks had been undertaken prior to employment. For example, a check of references was not recorded for some recently recruited members of staff. However, the practice had checked staff members' qualifications, registration with the appropriate professional body, and had undertaken criminal records checks through the Disclosure and Barring Service for all staff members.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. The practice had an on-call system to help ensure that other staff members could cover unexpected absence. During the week of the inspection one doctor was away on sick leave. Patients with appointments had been contacted and their appointments rearranged, transferred to a different doctor or their problem had been suitable for a telephone consultation with another GP. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed and visible to staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and interviews showed that all staff had received training in basic life support within the last two years and knew how to respond to an emergency. 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). When we asked members of staff, they knew the location of this equipment and records confirmed that it was checked regularly.

The practice kept a small stock of medicines for use in an emergency. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice nurses were responsible for checking whether emergency medicines were within their expiry date and suitable for use and we saw records showing these checks were completed. 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 might affect the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, failure of computer systems, adverse weather, unplanned sickness, and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire evacuation simulations.

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 for common conditions, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners.

We saw minutes of practice meetings where particular topics and guidelines were discussed and shared. For example, a recent clinical meeting had focused on the treatment of depression. The implications for the practice's performance and patients were discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and reviewed care and treatment when appropriate, for example, if a patient's condition was not improving as expected.

Individual GPs led in specialist clinical areas such as diabetes, substance misuse, learning disability and mental health, and the practice nurses and health care assistants supported this work. For example, one health care assistant was responsible for setting up the room for minor surgery and assisted during these procedures. The practice ran a number of specialist clinics covering long-term conditions such as diabetes and offered assessment and referral for patients potentially eligible for specialist weight loss (bariatric) surgery. The GP and practice nurse team had developed special clinical interests around substance misuse, minor surgery, mental health and bariatrics which were linked to the needs of the local population.

The practice manager showed us the practice's Quality and Outcomes Framework (QOF) results and data collated by the Clinical Commissioning Group of the practice's relative performance on a range of measures (such as practice immunisation rates). QOF is a national performance measurement tool.

The practice performance was generally comparable to similar practices or better in a number of areas. National data showed that the practice was in line with referral rates to secondary and other community care services. The practice had systems in place to ensure that GPs were able to meet national standards, for example, for the referral of patients with suspected cancers who were referred within two weeks.

The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families towards the end of life or who had particularly complex health conditions.

Management, monitoring and improving outcomes for people

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff and the practice as a whole.

We did not see an annual audit plan for the practice but individual GPs described a number of recent clinical audits to check that their practice was in line with recognised standards and to identify areas for improvement. For example, the practice had recently conducted an audit of postnatal care and information and an audit on patients who had undergone splenectomy. The splenectomy audit had been repeated to check that identified improvements had been implemented and sustained. Other examples included ongoing audit to confirm that minor surgery was conducted in line with NICE guidance.

The practice participated in local benchmarking exercises run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to other similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable to other practices. Clinical audits and data collection exercises were also undertaken as part of the practice participation in the QOF and other contractual requirements.

The doctors and nurses had opportunities to reflect on the quality of the service. The mechanism for this was primarily through a weekly clinical meeting. The health care assistants we spoke with said they were informed of key developments affecting their practice but they did not attend the weekly clinical meeting. They said it might be useful to attend these meetings too. The practice manager told us the attendance at this meeting was under review.

Good

Are services effective?

(for example, treatment is effective)

Mental health was an identified need in the local area and some practice staff members were actively participating in a research project on personality disorder in primary care with colleagues in two other practices. A scientific paper to share the results was in preparation.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with most mandatory courses such as annual basic life support. The practice manager monitored attendance. The GPs were up to date with their yearly continuing professional development requirements and had either 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The wider staff team also received annual appraisals. The appraisal documentation included consideration of learning needs, and any learning plans and agreed actions were signed by both the appraiser and staff member being appraised. We saw examples of staff members identifying clinical training needs, for example on wound management which were supported. Interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice was a training practice, that is, doctors who were training to specialise as GPs undertook a working placement at the practice under supervision. The practice was hosting five GP trainees (registrars) at the time of the inspection. The registrars had extended appointments with patients and had access to a senior GP throughout the day for support. We spoke with two registrars who were enthusiastic about the practice and the support they were receiving. The practice's previous report from the London Deanery (the body responsible for ensuring that medical training meets required standards) was positive about the quality of training and support provided to registrars. The report recommended that registrars become more involved in the management of long-term conditions and the practice had acted on this. We saw that the registrars attended clinical team meetings and multi-disciplinary team meetings to review complex cases.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were appropriately trained and supported to fulfil these duties, for example, on cervical cytology. Those with extended roles, for example initiating insulin starts for eligible patients with diabetes, could demonstrate they had appropriate training, the ongoing support of their GP colleagues and were confident they were acting within their competencies.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. The practice communicated with out-of-hours services electronically and was made aware the next morning of any patients who had required care out-of-hours who might need following up. The clinical staff told us they were able to contact specialist consultants from a range of specialties for advice on the management of specific cases. We spoke with one patient who told us they had complex health needs and the practice had effectively coordinated their care with a number of other health and social care agencies.

The practice held multidisciplinary team meetings for example, to discuss the needs of complex patients and those with end of life care needs. These meetings were attended by district nurses, palliative care nurses, and a geriatrician and decisions were documented in patients' individual care plans. The practice followed the Gold Standards Framework for end of life care.

The practice was involved in an enhanced services contract to transfer and manage patients with mental health problems within the primary care team. GPs conducted joint consultations and assessments with the local mental health psychiatric liaison worker who was attached to the practice with the consent of patients. The GPs told us that joint assessment was proving valuable because it meant that patients were referred promptly to the appropriate specialist services; patients were being managed better in the community and patients' physical health problems were not overlooked. Two of the GPs had a special interest in mental health and had undergone additional training and achieved further qualifications. The practice was able to make direct referrals to MIND when appropriate for ongoing counselling and advise patients about accessing the Improving Access to Psychological Therapies (IAPT) services in the area.

The practice worked with local substance misuse services to provide safe and appropriate drug replacement therapy to patients with a history of substance misuse. A drug and

alcohol sessional worker attended the practice weekly to support this work. The GPs were aware of the importance of actively promoting recovery from drug dependency with these patients.

The practice maintained a register of people with learning disabilities. One of the GPs took the lead for learning disabilities to provide continuity of care. People with learning disability received an annual health checks. The practice provided joint consultations and assessments with the community learning disabilities nurse to ensure that patients' wider needs were addressed. We reviewed the records of five patients with learning disability which confirmed that people were receiving health checks and treatment in line with their assessed needs. The practice offered longer appointments for people with a learning disability or other complex needs.

Information sharing

The practice communicated with other providers electronically. Electronic systems were in place for making referrals, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). One staff member's role specifically focused on managing and supporting referrals, for example, they checked that patients had received a suitable appointment following referral and would follow-up delayed or missing appointments with the provider.

The practice had systems to provide staff with the information they needed. The practice had recently changed to a different electronic patient record (SystmOne) to coordinate, document and manage patients' care. All staff had received training on the system, and some commented positively about the system's ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that a risk assessment had been carried out to ensure that the move to the new system did not compromise or result in the loss of patient information.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in relation to this legislation. 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.

Patients with a learning disability and those with dementia were supported to make decisions and help develop a care plan. Care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Clinical staff understood the Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had a policy on obtaining consent for specific interventions. For example, we saw that patients' verbal consent to minor surgery was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence that the consent process had been checked in all cases.

Health promotion and prevention

The practice partners were aware of the needs of the practice population and how population needs were changing. This information was used to help focus health promotion activity and encourage patients with poor access to services to register with the practice.

New patients were offered health checks with a health care assistant. Any concerns were referred to a GP for follow up. GPs used their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and checking how new mothers were feeling emotionally at the six-week postpartum check. The practice offered NHS health checks to patients aged 40-75 to advise patients about their lifestyle risk factors and symptoms before these developed into more serious health conditions. The practice kept a register of all patients with a learning disability who were offered an annual physical health check. We reviewed the records of five patients with learning disability in which health checks and care plans had been documented.

The practice identified patients who needed additional support, and it was pro-active in offering additional help. The practice offered a range of condition-specific clinics to

Good

Are services effective?

(for example, treatment is effective)

promote health and advise people with particular conditions, and to support people to understand and manager their own conditions. A volunteer "expert patient" regularly attended the practice to talk with patients with diabetes and signpost them to other useful resources in the community.

The practice's performance for cervical smear uptake in 2013/14 was 76% which was in line with other practices in the Clinical Commissioning Group (CCG). The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations at 24 months and five years was above average for practices in the CCG, with a clear policy for following up non-attenders. For example 88% of eligible five year olds in the practice completed their MMR vaccinations compared with the CCG average of 73%.

The practice underperformed for rates of flu vaccination in 2013/14 relative to other practices in the CCG area. We were told that this was being addressed with walk-in vaccination sessions throughout October, opportunistic vaccination when eligible patients attended the practice for other reasons and through targeted visits to people who were housebound and in residential care settings. We saw information displayed in the reception area and on the website promoting the flu vaccination campaign.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National GP Patient Survey and the practice's own annual patient survey results. The evidence from these sources showed patients were satisfied with how they were treated. For example, data from the national GP patient survey showed that 55% of practice respondents would "definitely recommend" the practice to others compared to the Clinical Commissioning Group (CCG) average of 45%. The practice performed in line with the CCG and England averages for its satisfaction scores on consultations with doctors with 84% of practice respondents saying the GP was "good" or "very good" at listening to them and 84% also saying the GP gave them enough time.

Twelve patients completed feedback forms to tell us what they thought about the practice. These were all positive about the service experienced. Patients described the service as excellent and the staff as helpful, understanding and friendly. We also spoke with 11 patients on the day of our inspection. All told us they were happy with the care provided by the practice and said their dignity and privacy were respected.

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 was maintained during examinations, investigations and treatments. We noted that consultation and treatment 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 personal information was kept private. The practice switchboard was located on the first floor and away from the reception area.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and generally rated the practice well in these areas. For example, data from the national patient survey showed 76% of practice respondents said the GP involved them in care decisions which was in line with the CCG and England scores. Eighty-nine per cent reported the GP was good at explaining treatment and results. This score was higher than the CCG average of 80%. The results from the practice's own satisfaction survey showed that patients were positive about the quality of care they received from doctors, nurses, health care assistants and the reception team.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The website included information in a range of languages about how to book an interpreter.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with and the feedback forms we received described the staff as understanding and compassionate. Notices in the patient waiting room and patient website informed patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. Staff told us that if families had suffered bereavement, they were contacted and referred to counselling and bereavement services. The practice followed the Gold Standards Framework when caring for a patient known to be coming to the end of their life. This approach emphasised the importance of sensitively involving the patient and their families in making decisions about their care at this time.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood within the context of the broader commissioning priorities for the borough and the socio-demographic profile of the population. The GP partners engaged with other GP practices, local commissioners and other organisations to provide and maintain a service that met patients' needs, for example contracting with a local nursing home to provide the people living there with responsive primary care.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the practice patient reference group. For example, the reference group had identified telephone access and a lack of awareness of online booking as issues in the latest practice patient survey. As a result, the practice was monitoring the time taken to respond to telephone calls and had displayed information about online booking in the waiting area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Services for patients were located on the ground floor. 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.

The practice could cater for other different languages through translation services.

Access to the service

The practice was open most weekdays from 08:00 until 20:00; from 07:00 until 20:00 on Wednesday and Thursday and also on Saturday mornings. Walk-in appointments and telephone consultations for urgent health problems were available from 09:00 until 17:00 every weekday.

Comprehensive information about appointments was available to patients on the practice website. This included information on opening times, 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 people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. One of the GPs was the lead for the care of patients resident in a local care home and visited the home weekly.

The practice scored highly in the 2014 National GP Patient Survey on access. Eighty-eight percent of patients reported being able to get an appointment when they wanted compared to the Clinical Commissioning Group area average of 69% and the England average of 73%. The practice offered bookable appointments and emergency consultations the same or next day with a duty doctor. Most of the patients we spoke with during the inspection had been seen by the emergency duty doctor and thought this system worked well.

The practice doctors had a contract with a homeless charity to engage homeless people who tended not to engage with health services despite having high physical and mental health needs. The practice partners had visited this hostel to provide accessible consultations and encourage people to register as patients. We were told that a number of patients had successfully registered with the practice and maintained contact following this intervention with benefits to their health. The practice partners had additionally donated administrative time to support this work.

The practice provided people with complex or more challenging needs with a named doctor. The electronic records system alerted reception staff about patients who usually required longer appointments.

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.

We saw that information was available in the practice leaflet to help patients understand the complaints system. This was, displayed in the waiting area and on the practice

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

website. Some but not all 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 needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found these had been handled in line with the practice policy. One complaint had been referred to NHS England for resolution and had been partially upheld. The practice had documented how this was going to be followed up with the patient concerned.

We saw that complaints were taken seriously and investigated in a timely way. Patterns were identified if they related to, for example, individual members of staff and followed up through the appraisal and performance process. Where complaints were upheld the practice wrote to the patient, apologised and informed them of actions taken to reduce reoccurrence. Complaints were used as a source of learning and actions shared with the staff team.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The vision and practice values were used to focus the practice's strategy and business planning. The practice partners had recently attended an away day to discuss their objectives for the future. They had identified six strategic aims for the practice including: "to provide very high quality in all we do"; to be "outward focused"; to encourage "innovation" and to place a high priority on education and training. Members of staff we spoke with were aware of the practice vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had developed policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice and paper copies were also available in the first floor office. The policies we saw had been reviewed within the last twelve months. The members of staff we spoke with were clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was achieving well, including against measures of how well organised they were, for example, on record keeping and obtaining patient feedback. Progress against the QOF and other contractual targets was monitored by the practice manager and the partners.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. There were designated leads for specific areas of risk, for example, there was a lead nurse for infection control and named clinical leads for safeguarding.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. The GP partners individually took the executive lead in the practice on a rota basis for a number of months with their clinical sessions being covered by the other doctors in the team. The executive GP lead had fewer clinical sessions and protected time to carry out this role effectively. The executive GP lead role included internal management responsibilities and engagement with strategic partners in the community, for example, the clinical commissioning group. One of the GPs was leading the development of a "federation" of GP practices in the area and was able to describe the long term aims of a federation for the local area. The GP partners we met spoke positively about taking advantage of available opportunities to develop primary and integrated services for their patients.

The practice partners were also reviewing how to develop the skills of the whole practice team, in particular the health care assistant roles to better meet local needs. They had not yet engaged the health care assistants or other staff in these discussions however.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that there had been an all staff away day in the previous six months.

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

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through national patient survey results, its own annual patient survey, reviews on the internet, comment cards and complaints. We looked at the results of the practice's 2014 patient survey. The practice had agreed an action plan with the patient reference group based on the results. The main issue raised was the length of time it took patients to get through to the practice by telephone. The practice had recently introduced a "call centre" arrangement and now had dedicated staff answering the telephones in a separate office. This arrangement also had the benefit of ensuring

Are services well-led?

Good

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

that the receptionists and patients were not interrupted by telephone calls. The practice was able to monitor the length of time taken to answer telephone calls and had introduced target times for response.

The practice had worked hard to ensure that the patient reference group was representative in terms of ethnic diversity, age and employment status, for example, recruiting patients from a nursing home and making efforts to recruit patients from more vulnerable groups.

The practice gathered feedback from staff through staff away days, staff meetings, appraisals and informal discussions. Staff told us they were comfortable giving feedback and could discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The health care assistants said they would like to be more involved in clinical team meetings and this was under review.

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

Education and training was a strategic priority for the practice and this was reflected in practice. Four of the GP partners were accredited GP trainers and the practice hosted GP training registrars from two postgraduate training programmes.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We were consistently told that the practice encouraged staff development in order to improve services for patients.

The practice management disseminated learning across the staff team. For example, we asked staff about specific significant incidents that had occurred within the previous twelve months. Staff members could recall the events in question and the key learning points for their day to day practice.