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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.

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Overall summary

Dr Kumara Srikrishnamurthy is a GP surgery which provides a primary medical service to patients in the Queen's Park areas of the London Borough of Westminster. The practice currently has about 2300 patients on its list. The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures; maternity and midwifery services; surgical procedures; and treatment of disease, disorder or injury.

We carried out an announced inspection of the service on 21 May 2014. The team, led by a CQC inspector, included a GP, a CQC bank inspector and an expert by experience.

The majority of patients we spoke with and received comments cards from during our inspection made positive comments about Dr Kumara Srikrishnamurthy and the service provided. Patients who used the practice told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect. They were complimentary about the caring, helpful attitude of the GP, nurses and administrative staff. Most patients were happy about the appointments system but some patients expressed their dissatisfaction with the time spent waiting to see the doctor when they came for an appointment.

The practice provided a safe, effective, caring, responsive and well led service. There were arrangements in place to ensure patients in all population groups were kept safe. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. We saw from our own observations and heard from patients they were treated with dignity and respect. The practice understood the needs of its patients and was responsive to them. The practice had a clear ethos which put patients first and was committed to providing them with the best possible service. There was an open culture and staff felt supported in their roles.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe. The practice learned from incidents to improve the safety of the service. Lessons learned were communicated within the practice and action implemented and followed up. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. Systems in place to reduce the risk and spread of health acquired infection were in most respects effective, although there was no written protocol for cleaning the treatment room before and after minor surgery. There were appropriate arrangements for the management of medicines. There were effective arrangements in place and equipment available to deal with medical and other emergencies. There were some shortcomings relating to the premises.

Are services effective?

The practice provided an effective service. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. The practice participated in clinical audits and external peer group meetings and this contributed to improvements in areas of clinical care. There were appropriate arrangements in place to monitor review, and improve performance. There were arrangements in place to support staff appraisal, learning and professional development to secure improvements in the service. The practice worked in collaboration with other health and social care professionals to provide integrated patient care and support their needs. The practice promoted good health and prevention and provided patients with suitable advice and guidance. Appropriate referrals were made to other agencies in support of this.

Are services caring?

The practice provided a caring service. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect. We observed patients being dealt with in a friendly and courteous manner. The arrangements for ensuring patient privacy and confidentiality were not as effective as they could be. Patients were involved in decisions about their care. Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Where patients did not have the capacity to consent, the practice acted in accordance with legal requirements.

Summary of findings

Are services responsive to people's needs?

The practice understood the needs of its patients and was responsive to them. There were arrangements in place so patients whose first language was not English could access the service and communicate their needs. Some written information was provided in a different language. There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met. The practice took part in local schemes and projects to provide enhanced services. Patients were able to access appointments when they needed them. The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Are services well-led?

The practice was well led and had a clear ethos which put patients first and was committed to providing them with the best possible service. There was an open culture and all staff had clearly defined roles which they knew and understood. Staff said they felt supported in their work where continuous learning and development was encouraged. There were established governance arrangements through which risk and performance monitoring took place and service improvements were identified. There was an effective system for obtaining and acting on feedback on service delivery through the patient participation group.

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

The service to older patients was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. There were effective arrangements to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. There were arrangements in place for engagement with other health and social care providers.

There were appropriate and effective end of life care arrangements in place. The practice participated in a number of Local Enhanced Services (LES) Direct Enhanced Services (DES) schemes to improve the management and delivery of care to specific patient groups which also covered older patients. Home visits were carried out by the GP for those who were not well enough to attend the surgery. The practice also worked closely with district nurses to support the care and treatment of housebound patients.

People with long-term conditions

The service to patients with long term conditions was safe, effective, caring, responsive and well led. There were safe arrangements in place to review medicines for patients with long term conditions. The practice had effective arrangements to help patients manage their long term conditions. The practice took part in regular clinical learning set (CLS) audits relating to long term conditions.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups with long term conditions.

Mothers, babies, children and young people

The service to mothers, babies, children and young people was safe, effective, caring, responsive and well led. There were effective arrangements in place to safeguard children and young people. There were arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people. Patients we spoke with told us they felt involved in making decisions about their care and treatment. Mothers we spoke with confirmed they were always asked for

Summary of findings

consent before their children were treated. There were specific services and health promotion clinics available for this population group. Special arrangements were in place to enable improved access to appointments.

The working-age population and those recently retired

The service to working age patients (and those recently retired) was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. The practice carried out regular monitoring of individual patients to ensure care and treatment remained suited to their needs. Patients were asked for their consent to treatment and felt involved is decisions about their care. Patients received advice and guidance about making healthy life style choices. A late opening clinic was available for those patients who could not get to the surgery during regular working hours.

People in vulnerable circumstances who may have poor access to primary care

The service to patients in vulnerable circumstances who may have poor access to primary care was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. The practice regularly monitored and reviewed risks to individual patients and updated care plans accordingly. There were arrangements in place to support specific groups, for example patients with learning disabilities, drug and alcohol problems and the homeless. The practice did not have any travellers or sex workers registered. The appointments system was arranged to facilitate access for patients in this population group.

People experiencing poor mental health

The service to patients experiencing poor mental health was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. The practice had effective arrangements for monitoring and reviewing patients in this population group, including their medicines. There was a multidisciplinary approach to ensure integrated care for these patients. The practice facilitated and encouraged access to mental health support and counselling services. Where patients lacked capacity, appropriate account was taken of the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

The majority of patients we spoke with and received comments cards from during our inspection made positive comments about Dr Kumara Srikrishnamurthy and the service provided. Patients who used the practice told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect. They were complimentary about the caring, helpful attitude of the GP, nurses and administrative staff.

Most patients were happy about the appointments system but some patients expressed their dissatisfaction with the time spent waiting to see the doctor when they came for an appointment.

The practice carried out an annual patient survey through the patient participation group (PPG). They produced an action plan in response to the survey results. The response to the 2014 survey was mostly positive but some areas for improvement were highlighted. The main actions were to carry out a trial to make the last hour's appointments a priority for working patients and children. There was also an action to run a separate clinic session for childhood vaccinations to avoid children having to wait unduly. Prior to the inspection four patients wrote to us direct in response to a short survey initiated by the practice, looking at the areas we covered in the inspection. All four were very complimentary about the service they had received.

Areas for improvement

Action the service COULD take to improve

- There were some shortcomings relating to the premises which the practice could address to avoid potential risks to patient safety.
- Under its infection control arrangements the practice lacked a written protocol for cleaning the treatment room before and after minor surgery.
- The practice could review its arrangements to ensure patient privacy and confidentiality was maintained during consultations.

Good practice

Our inspection team highlighted the following areas of good practice:

- The direct involvement of patients in determining improvements in practice as a result of formal complaints.

Dr Kumara SrikrishnamurthyDr Kumara Srikrishnamurthy

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector** and a **GP** and the team included a CQC Inspector and an Expert by Experience. The GP and Expert by Experience were granted the same authority to enter Dr Kumara Srikrishnamurthy's practice as CQC inspectors.

Background to Dr Kumara Srikrishnamurthy

Dr Kumara Srikrishnamurthy is an individual GP who provides a primary medical service to approximately 2,300 patients in the Queen's Park areas of the London Borough of Westminster. The service is provided from a single premise on the Harrow Road. A significant proportion of patients using the practice were from the Bangladeshi community. The area is deprived with high unemployment. The majority of patients were of within the population group working age patients (and those recently retired) – aged 19 to 74. A relatively large number of patients were children and those over age 65. Over a third of patients were being treated for long term conditions, including significant numbers with hypertension, diabetes and asthma.

Out of hours patients were advised to call 111. Patients were also provided with information on two local practices they could access for weekend services and a minor injuries unit.

At the time of our inspection, the GP was supported by a practice manager, nurse practitioner and assistant practice manager, practice nurse, receptionist and a data entry clerk.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We liaised with the West London Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We carried out an announced visit on 21 May 2014. During our visit we spoke with a range of staff including the GP, the nurse practitioner and assistant practice manager, the practice nurse and the receptionist. We also spoke with a drug and alcohol project co-ordinator who was running a clinic at the surgery on the day of the inspection. We spoke with 10 patients who used the service and one member of the practice's patient participation group (PPG). We reviewed comments cards left by 26 patients sharing their views and experiences of the service.

We observed how people were being cared for during our visit. We reviewed information that had been provided to us at the inspection and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, audits and risk assessments and related action plans, staff records and health information and advice leaflets.

Are services safe?

Summary of findings

The service was safe. The practice learned from incidents to improve the safety of the service. Lessons learned were communicated within the practice and action implemented and followed up. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. Systems in place to reduce the risk and spread of health acquired infection were in most respects effective, although there was no written protocol for cleaning the treatment room before and after minor surgery. There were appropriate arrangements for the management of medicines. There were effective arrangements in place and equipment available to deal with medical and other emergencies. There were some shortcomings relating to the premises.

Our findings

Safe patient care

The practice had appropriate procedures in place to report and review incidents, complaints and safeguarding concerns and ensure safe patient care was maintained. The number of incidents was low but where they had occurred investigations, outcomes and actions were clearly documented. All patients we spoke with during the inspection told us they felt safe in the care of the doctor and nurses at the practice.

There were robust arrangements for monitoring patients prescribed high risk drugs. The practice said regular reviews and medicines management plans were in place for those patients on anticonvulsant and mood stabilizing drugs such as carbamazepine, lamotrigine, phenytoin and valproate.

There were some shortcomings relating to the premises we found during our visit. A section of the hand rail was loose at the bottom of the stairs leading to the first floor. Some of the steps on the stairs to the first floor were showing signs of wear and the vinyl flooring in the first floor toilet had bubbled up in places. With further deterioration, both could present a tripping hazard. There was a toilet for disabled patients with a sliding door and low level sink. However, the hand dryer was positioned out of reach. There was no emergency pull cord for a patient to summon staff support should they require help.

Learning from incidents

Significant events were analysed to identify if there was any learning for the practice. These were discussed and audited regularly at team meetings. Where appropriate, changes to processes or systems were identified as a result of the significant event. Staff were aware of the process to follow and we saw the form used for this purpose. This included a root cause analysis, grading of the incident, identification of potential future risk, a description of the incident and improvement strategies. We were told of one incident of a patient discharged from hospital with the incorrect dosage of medicine. This was reviewed at a monthly practice multidisciplinary meeting held with a district nurse, the community matron, a drug and alcohol adviser, a member of the local mental health team and representatives from social services.

Are services safe?

The practice received Medicines and Healthcare Products Regulatory Agency (MHRA) medicine safety alerts by email and these were followed up by the nurse practitioner and GP.

Safeguarding

The practice had safeguarding policies in place for both children and vulnerable adults which included contact details for local safeguarding agencies. These contact details were also displayed in the practice office. Staff knew how to recognise signs of abuse and the process to follow if they suspected abuse. The practice was currently providing clinical input to one case. We saw from the minutes of a recent practice meeting with the primary care navigator, a mental healthcare professional, and district nurse that there was discussion and agreed follow up action of high risk patients and any safeguarding cases.

The practice completed a safeguarding self-evaluation audit in November 2012 which showed training was up to date and all necessary criminal record checks had been completed. We reviewed the current situation and saw that staff had undertaken child protection training at the appropriate level, clinical staff level 3 and non-clinical staff level 1. We noted that the practice nurse had not recently attended refresher training in safeguarding vulnerable adults.

There was CCTV in operation. The practice was properly registered with the Information Commissioner's Office for this and there were signs informing patients of its use. The system had been installed primarily for patient and staff safety. There had been no incidents in the practice which had required footage to be reviewed but the Police had accessed this for a public incident which had occurred in the street outside the practice.

Monitoring safety and responding to risk

The practice had risk management processes in place. These included a business continuity plan which had been adapted from a template, although some areas had not been fully tailored to the practice. For example, we noted the document referred to an 'emergency box' but there was no such box available.

The practice carried out regular health and safety risk assessments. We saw the equipment risk audit completed in November 2012 and noted the action plan from it had been implemented. There was a risk assessment for the security of the premises carried out for 2013/14. No serious issues were identified. The nursing practitioner and assistant practice manager told us that in addition to formal assessments staff carried out continuous informal checks on the premises on a day to day basis.

The practice had emergency equipment available including a defibrillator and oxygen cylinder. Staff completed weekly checks of oxygen levels and defibrillator operation and we saw the records for this. Staff had received up to date training in dealing with medical emergencies.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. We were told audits for smear tests and minor operations were carried out at the practice. We were also told of an audit relating to the patients who attended the drug and alcohol clinic which had been carried out by the Westminster Shared Care Community team. The practice reviewed the audit outcomes and drew up management plans, including safeguarding for individual patients. We were told there would be a follow up audit to check on the effectiveness of the changes implemented in these plans.

Medicines management

The practice had a policy for repeat prescribing and protocols for prescription security and the safe disposal of medicines. Patients told us their prescriptions were processed within 48 hours and this ensured they had their medicines at the times they needed them. Requests were handled over the phone or in person. We heard from one patient about the good advice they had received from the doctor about medicines for hay fever.

We were told patient records were flagged to identify when they were due for a medicine review and arrangements were made for them to attend the surgery or receive a home visit for this if they were housebound. The practice participated in local audits and other reviews around medicines management including a prescribing improvement plan overseen by the local Medicines Management team. The practice was required to submit an action plan. The latest plan included an action to provide additional education to patients and staff and prescribing reviews of patients on specific medicines. The practice also carried out its own audits, for example of its repeat prescribing protocol in response to a formal complaint.

Appropriate arrangements were in place to maintain the cold chain in the storage of vaccines. We saw records of the

Are services safe?

daily checks on temperature ranges and looked at a sample of vaccines which were all in date. Emergency drugs were in date and regular stocks checks were carried out.

Specific population groups were being targeted for medicines management support. The local pharmacy provided pill organiser boxes for patients aged 75 or over to assist them in administering medicines prescribed by the practice. Patients who were trying to stop smoking were given tokens so they did not need a prescription for nicotine patches and gum. Patients with long term conditions had an annual medical check which included a review of medicines, for example patients with asthma had their prescribed steroids reviewed to ensure they were still suitable.

Cleanliness and infection control

The practice used an infection prevention control (IPC) 'tool kit' to ensure appropriate standards of cleanliness and prevent and control infection. The practice nurse was the named infection control lead. Clinical and cleaning staff were trained in IPC and we saw the certificates for this. Staff were provided with personal protective equipment including gloves, masks, disposable aprons, protective glasses and goggles.

We noted the practice was subject to regular infection control audit by the local Commissioning Support Unit (CSU). The practice had an audit in November 2012 and we saw that action identified had been implemented, for example to install disposable curtains in treatment rooms. The practice had recently completed a self-assessment for the 2014 audit and were awaiting the audit visit. The self-assessment had not identified any significant issues. However, we found there was no written protocol for cleaning the treatment room before and after minor surgery.

The practice had a comprehensive cleaning plan and checklist and we saw the record of a recent spot check and action identified. We noted the cleaner did not routinely record on the checklist that the necessary actions had been completed. Hand wash audits had been completed for nursing staff and no issues identified. Antibacterial hand gel was available for use in clinical areas.

The practice had infection and hazard control policies in place. All staff had been offered Hepatitis B immunisation and we saw the immunisation records for this. The cleaning cupboard was kept locked and keys held securely. Cleaning products and equipment were appropriately stored. There was a waste management contract in place for the collection of clinical waste, including sharps bins. Sharps bins in consultation rooms were appropriately labelled, signed and dated.

Staffing and recruitment

The practice told us there were sufficient staff to meet the needs of patients using the service. We noted though, as an individual, the GP often worked beyond stated surgery finishing times to ensure no patients suffered any detriment in the service provided.

The practice had a recruitment policy and procedure which included a documented interview process and appropriate pre-employment checks to ensure that patients were cared for and supported by suitably qualified, skilled and experienced staff.

We found most of the staff had been employed before the provider was registered with the Care Quality Commission and there had been little recent recruitment activity as staff turnover was low. The practice could not therefore evidence the completion of recruitment processes. However, the practice was in the process of reviewing its staff records to provide up to date information on identity and criminal records. All staff had had criminal record checks but the GP was applying for an updated check. Professional registration was up to date for clinical staff. We spoke with the most recently recruited member of staff who told us they provided a CV when they applied for the post and received an interview from the practice manager. They said they had been asked to provide references and proof of address and had completed a criminal records check. They confirmed they had received a thorough induction which included work shadowing with other members of staff.

Dealing with Emergencies

The practice business continuity plan set out the arrangements to be followed in the event of major disruption to the practice's services. Staff were aware of the plan and we saw that it had been discussed at practice meetings. To help maintain services the practice was part of a virtual private network (VPN) with a nearby 'buddy practice'. This enabled them to share the computer network and work from the buddy practice in the event of a major disruption.

Are services safe?

There were monthly fire alarm tests and a designated evacuation assembly point if the building had to be vacated. We looked at the fire drill and evacuation plan and noted from staff meeting minutes that these had been discussed and drills had been carried out.

Equipment

The practice had a buildings and estates management policies and protocols document which covered issues such as opening and closing procedures, buildings and equipment maintenance, health and safety risk assessment and CCTV policy and procedures.

Fire extinguishers had been recently checked and there were records that portable appliance testing had been carried out in May 2014. The gas boiler had been checked on March 2014 and the annual check of the oxygen cylinder had been completed. Other medical equipment tests and calibration checks to ensure they remained suitable for use had been completed in May 2014.

The practice nurse ensured adequate stocks of medical supplies were maintained, such as syringes, needles, blood test containers and disposable curtains. The practice nurse undertook this in liaison with the nurse practitioner who was responsible for the orders for vaccines, surgery equipment and emergency drugs. There were appropriate records maintained for stock and equipment orders.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice provided an effective service. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. The practice participated in clinical audits and external peer group meetings and this contributed to improvements in areas of clinical care. There were appropriate arrangements in place to monitor review, and improve performance. There were arrangements in place to support staff appraisal, learning and professional development to secure improvements in the service. The practice worked in collaboration with other health and social care professionals to provide integrated patient care and support their needs. The practice promoted good health and prevention and provided patients with suitable advice and guidance. Appropriate referrals were made to other agencies in support of this.

Our findings

Promoting best practice

Best practice standards and guidelines were followed in the assessment and planning of patients' healthcare needs. The GP kept up to date with relevant professional guidance through continuing professional development, for example by attendance at a Royal College of General Practitioners course on minor surgery. The GP also used a web-based mentor system to track and record learning and 'Map of Medicine', used by doctors throughout the NHS to determine the best treatment options for their patients.

Practice nursing staff attended a nursing monthly lunch time forum at the buddy practice to discuss medical practice issues. This forum also provided access to CCG funded courses and training, for example, smear test training and family planning updates. We saw the training certificates for this.

There were arrangements in place to obtain and record a patients' consent, including when obtaining consent when treating children. Where patients lacked capacity the practice took account of the Mental Capacity Act 2005 and involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment.

Management, monitoring and improving outcomes for people

The practice actively participated in clinical audit and there was evidence of the completion of clinical audit cycles. The practice was a member of the local commissioning learning sets (CLSs) established by West London Clinical Commissioning Group (CCG) to foster collaboration and learning amongst members, sharing and benchmarking data, improving performance, spreading good practice, generating ideas for new services or improvements to existing ones. The practice had taken part in regular CLS audits, for example on inappropriate outpatient referrals, avoidable A&E attendances and emergency admissions. The practice collated its results and presented them at monthly CLS peer review meetings. The practice reviewed the outcomes and action plans where required at practice meetings. We noted in response to the audit on emergency admissions the practice was set a target of reducing admissions by eight over a period of twelve months from 1 April 2013 to 31 March 2014.

Are services effective?

(for example, treatment is effective)

The practice also carried out regular monitoring of individual patients to ensure care and treatment remained suited to their needs. The GP reviewed the patient list and informed the receptionist of patients due a recall to the practice for review. The receptionist contacted patients to arrange a recall appointment. Patients could book a recall appointment three to six months in advance.

Staffing

The practice had an induction checklist, although records to evidence its completion were not readily available as the majority of staff had been in post for some time.

The practice encouraged continuous professional development and there were arrangements in place for the completion of mandatory refresher training. Mandatory training was mostly up to date including fire safety, safeguarding, infection control and medical emergencies. The receptionist also told us of online training completed on equality and diversity, conflict resolution, and information governance, including patient confidentiality. The nursing staff were trained in carrying out smear tests and immunisation and one of the nursing team had attended a training course on care of patients with dementia.

There were appropriate arrangements for staff appraisal and supervision. Staff received an annual appraisal and informal one to one supervision. The appraisal process included a review of performance and objective setting, including the identification of learning and development needs. Practice meetings offered a further opportunity to discuss work related and operational issues. Staff told us they liked working at the practice and the GP was very supportive in relation to training and development.

Working with other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach for patients. The practice attended multidisciplinary team (MDT) integrated care pathway meetings each month to consider the care management of specific patients with complex needs requiring an MDT input.

The practice met with the nearby 'buddy' GP practice three times per year to peer review patient referrals and identify where improvements in referral practice could be made.

The practice participated in a Putting Patient First local enhanced service (LES) under which meetings were held monthly with district nursing and the community matron to discuss complex care planning and review patients at risk of hospital admissions. This was then followed up at practice meetings where specific action for an individual patient was discussed and highlighted, for example to ensure patients with mental health problems received the medicines they needed on discharge. The practice also facilitated patients' access to the Westminster 'Improving Access to Psychological Therapies (IAPT) programme which provided self-help courses for patients with common mental health difficulties such as stress, worry and low esteem. In addition carers were referred to the 'Carers Network' to access financial and social support.

Health, promotion and prevention

All new patients completed a detailed registration form which together with an initial examination or health check formed the basis for assessing any support of health promotion needs. There was a range of health promotion information available in the reception area including leaflets about chlamydia, contraception, smoking cessation, and immunisation for children. Where additional information was required about specific conditions and treatment, the GP and nurses were able to search for and print leaflets from the clinical system service which gave on-line access to support resources for clinicians and patient information leaflets.

The practice website, which was still under development, highlighted the special services and health promotion clinics available. These included daily run antenatal and post natal clinics, a child health and immunisation clinic, family planning, pregnancy advisory service, sexual health and free condom distribution, an asthma clinic, a diabetic clinic, anti-smoking, hypertension, coronary heart disease and stroke prevention and management clinic, travel immunisation clinic, and diet and exercise clinic. There was also a cervical smears service provided by a female nurse practitioner and a general health check-up for patients.

Where appropriate, patients were referred to the diabetic clinic and the specialist dietician for dietary advice. The GP identified from patient records lists of patients for vaccinations and the receptionist phoned patients to book an appointment with the nurse. The GP also carried out screening appointments for heart disease and the nurse carried out spirometry testing for chronic obstructive pulmonary disease (COPD).

Are services effective?

(for example, treatment is effective)

Under a drug and alcohol Direct Enhanced Services (DES) scheme the practice screened all new registrations to identify patients in need of support: for a healthy lifestyle, this included a gym referral.

Are services caring?

Summary of findings

The practice provided a caring service. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect. We observed patients being dealt with in a friendly and courteous manner. The arrangements for ensuring patient privacy and confidentiality were not as effective as they could be. Patients were involved in decisions about their care. Before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Where patients did not have the capacity to consent, the practice acted in accordance with legal requirements.

Our findings

Respect, dignity, compassion and empathy

We spoke with 10 patients during the inspection and received comment cards from 26 others, a sample of whom we telephoned. Their comments were overwhelmingly positive about the way they were treated by the doctor, nurses and administrative staff at the practice. They told us of the respectful and courteous manner with which they were dealt with on the telephone and face to face. Many told us they had been coming to the practice for a number of years and of the very good relationship they and their families had with the GP and practice staff. The national GP Patient Survey 2013 recorded a rating of 'much better than expected' for confidence and trust patients had in the GP patients saw.

We observed good interactions between staff and patients both face to face and on the telephone. Patients were treated courteously and with respect. Telephone requests for repeat prescriptions were handled efficiently. There were arrangements in place to ensure privacy and confidentiality. Patients waiting to speak to the receptionist were asked to wait at the marked red line. The receptionist would only see one patient at a time at the desk. If the receptionist was on the phone, patients were asked to wait. The intention was that the receptionist would only speak to patients when others were out of hearing.

We saw these practices being followed during the inspection, although we noted from one comment card that some patients did not always observe the 'red line system'. In addition, the nurse's consultation room door was propped open and the conversations could be heard outside the room. When we raised this, we were told the door was normally closed to ensure privacy. We also found that some of the conversations in the drug and alcohol clinic could be overheard from the toilet next door. We discussed this with the GP who said they had another room where the clinic could be held to ensure privacy. No concerns were drawn to our attention by patients about privacy and confidentiality during our visit. Several told us their privacy was always maintained, including a substance misuser who felt this was very important to them. We noted, in addition, the majority of patients in the practice's 2014 patient survey rated confidentiality at reception as very good or good.

Are services caring?

The practice provided appropriate support for end of life care and those bereaved. A palliative care nurse visited the practice monthly to provide support to terminally ill patients and their relatives and carers. The GP provided emotional support during home visits for patients receiving end of life care. He worked with the palliative care nurse to manage their care, including pain management and advice. The majority of staff had been trained in the Gold Standards Framework (GSF).

Involvement in decisions and consent

Patients we spoke with and those who completed comments cards told us they felt involved in making decisions about their care and treatment. They were given sufficient time with the doctor or nurse and were able to ask questions and discuss the treatment they received. Two mothers said they were always involved in decisions about their children's care. Staff told us they used picture cards, mentor leaflets and interpreters to ensure patients understood care and treatment. The receptionist, who spoke the language of many patients, also acted as an interpreter. The receptionist had training in chaperoning and was available to provide this service. There was a notice about this service in the reception area.

We were told patients were offered choices about referrals to other services. Patients confirmed that when they had been referred they were able to give their preferences.

Patients were given appropriate information and support regarding their care or treatment. A range of information leaflets were available in the main reception area about health and practice issues. There was a practice leaflet which was provided to new patients. This contained information about the staff team and services provided, including what to do if somebody wanted to complain or make a suggestion, appointment booking, repeat prescriptions, test results, home visits, and out of hours care. This information was also available on the practice's website. Although there was some signage in another language in the reception area, the majority of patient information was in English and we did not see any in other formats, for example for patients with learning disabilities.

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes, including before minor surgery provided at the practice. When vaccinating children, if they were accompanied by a grandparent the nurse would always phone a parent to check consent. Mothers we spoke with confirmed they were always asked for consent before their children were treated.

There were arrangements in place to secure the consent of patients who lacked capacity in line with the Mental Capacity Act (MCA) 2005, involving family, carers, social services and advocates where appropriate. The practice worked with Westminster Advocacy service and referred patients to the service as needed. We were told of best interest meetings recently involving mental health professionals, social services and family carers in decision making and discussion of advice about treatment. As part of a learning disability service (LES) the practice worked with a local learning disability link nurse. The nurse visited the practice periodically to provide briefing on the MCA and consent issues.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice understood the needs of its patients and was responsive to them. There were arrangements in place so patients whose first language was not English could access the service and communicate their needs. Some written information was provided in a different language. There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met. The practice took part in local schemes and projects to provide enhanced services. Patients were able to access appointments when they needed them. The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Our findings

Responding to and meeting people's needs

Patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and were happy with the service provided. This was in most respects confirmed in patients' surveys conducted through the practice's patient participation group (PPG) but the practice took action to address areas identified for improvement. The PPG was set up to enable patients to provide feedback about the service and contribute to improvements in service delivery.

The practice engaged with commissioners of services and other providers to co-ordinate and provide integrated care which met the needs of the different population groups it served. The practice participated in a number of Local Enhanced Services (LES) and Direct Enhanced Services (DES) schemes to improve the management and delivery of care to specific patient groups.

There were appropriate arrangements in place for obtaining, communicating and following up the results of diagnostic tests. When patients were referred to community services or for hospital appointments, this was done through the national electronic 'choose and book' service that let patients choose their hospital or clinic and book their first appointment. Where possible, the practice referred patients to community diabetes, cardiology and dermatology services, rather than to hospital. Patients received appropriate and timely support from the practice following discharge from hospital.

There was continuity of care because as an individual GP, all patients always saw the same doctor. None of the patients we spoke with or received comment cards from told us they would prefer to see a female doctor. However, almost 50% of the practice's registered patients were female and we noted that with a male only GP available this impacted on some of the services provided. For example, the majority of breast examinations were done by nursing staff and we were told and that all patients were then referred to the community one-stop breast clinic. Similarly, if female patients required a pelvic examination they could be referred to the community gynaecology service

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients were mostly happy with the appointments system. They were able to get through to the practice on the telephone without undue difficulty. They could arrange urgent appointments when they needed them and did not have a long wait for non-urgent appointments which were usually available within a week.

Home visits were carried out by the GP for patients who were not well enough to attend the surgery. The practice had also introduced a telephone consultation service which had reduced pressure on the appointments system. We were told every patient who wished to be seen on the same day would either get an appointment or a telephone consultation.

The majority of patients we spoke with raised no specific concerns about waiting times when they attended for appointment. However, we received one comment card which raised long waiting times to see the doctor. The national GP Patient survey 2013 recorded a 'much worse for than expected' rating for the practice in relation to waiting times to see the doctor. We noted also 41% of respondents in the latest patient survey carried out by the practice reported they were still waiting 21-30 minutes before their appointment, although nearly half of them did not mind the wait while 23% felt they waited too long. The action plan in response to the practice survey set out steps they would be taking to improve waiting times including a new reception policy and prioritising patients appropriately.

The practice had recently introduced new late opening hours until 8pm on Wednesdays to accommodate working patients.

Repeat prescriptions were available within 48 hours of a request. For urgent or elderly patients the receptionist was able to 'fast-track' requests to make them available sooner.

Concerns and complaints

The practice had a complaints procedure in place and there was a complaints leaflet and form in the reception area. The leaflet provided patients with information about the complaints process and who to contact if they were dissatisfied about the outcome. None of the patients we spoke with or who completed comments cards told us they had any reason to complain.

Complaints raised were appropriately considered and responded to in writing. We noted there had only been four formal complaints in the last year and there were none currently under consideration at the time of the inspection. Complaints were discussed at practice meetings and lessons learned considered. We saw evidence of this in meeting minutes. At one meeting all formal complaints for the last year were reviewed including an analysis of the investigation and outcome and improvements in practice as a result. In one case we noted the complainant had been invited to take part in the practice's review of its reception policy in response to the complaint.

Are services well-led?

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

Summary of findings

The practice was well led and had a clear ethos which put patients first and was committed to providing them with the best possible service. There was an open culture and all staff had clearly defined roles which they knew and understood. Staff said they felt supported in their work where continuous learning and development was encouraged. There were established governance arrangements through which risk and performance monitoring took place and service improvements were identified. There was an effective system for obtaining and acting on feedback on service delivery through the patient participation group.

Our findings

Leadership and culture

The practice had a clear ethos which put patients first and was committed to providing them with the best possible service. Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England.

The practice had an informal management structure but it was led clearly by the GP and all staff had clearly defined roles which they knew and understood. There were clear HR policies and procedures to support staff. The GP fostered an open and learning culture and staff commented positively on the support they received.

Governance arrangements

There were regular practice meetings to consider clinical and practice operational issues. Complaints and significant events or incidents were also reviewed periodically and any lessons to be learned were discussed. There were monthly multidisciplinary meetings involving external health and social care professionals, including the district nursing team and social workers.

The practice had an information governance policy and improvement plan which was updated in November 2013. We saw that this had been emailed to staff requesting they read it. We noted the improvement plan was discussed at a practice meeting on 13 November 2013 and saw that action identified had been followed up, for example to complete outstanding staff training. There was a system for highlighting practice policies and ensuring that staff had read them which staff were required to complete. However, the practice acknowledged that the system was not working as effectively as it should be and there were gaps in the completion of records of staff having read the policies which the practice needed to address.

Systems to monitor and improve quality and improvement

There were systems in place to manage performance and identify areas for improvement. There were regular internal and external audits to support this which included checks of patient referrals, the environment, health and safety, and medicines. We found the practice proactively evaluated the services provided to continually improve the quality of service.

Are services well-led?

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

Patient experience and involvement

The practice had a Patient Participation Group (PPG) to enable patients to provide feedback about the service and contribute to improvements in service delivery. The PPG did not meet face to face but was conducted through email correspondence. We were told this was because meetings had proved impractical in the past. The GP initiated correspondence with the PPG. There were 38 patients on the membership list at the time of the inspection. There was a poster in reception about the PPG.

The practice carried out an annual patient survey through the PPG and produced an action plan to make improvements in response to the survey results. We saw the action plan for 2014 survey was discussed at a practice meeting in April 2014. The main actions were to carry out a trial making last hour appointments a priority for working patients and children and also to run a separate clinic session for childhood vaccinations to avoid children having to wait unduly. Prior to the inspection four patients wrote to us direct in response to a short survey initiated by the practice in relation to the areas we would be looking at during the inspection. All four were very complimentary about the service they had received.

Staff engagement and involvement

We saw from practice meeting minutes how staff were engaged and involved in practice matters. We saw discussion from a recent meeting of the business continuity plan including fire drills and evacuation plans and noted staff had been shown a training video. The meeting also discussed feedback from the patient participation group, complaints, the chaperone policy, the Mental Capacity Act 2005 and a 'toolkit' the practice had been using to help manage compliance with healthcare and social care regulations.

Staff told us they had opportunities to contribute to improvements in operational and clinical practice at practice meetings and on a day to day basis. During staff meetings and appraisals staff felt confident to raise issues and were listened to.

The practice had disciplinary and grievance policies which were reviewed in 2013. There were also human resource policies to support staff including a whistleblowing policy. Staff were aware of the whistleblowing policy and said it had been discussed at staff meetings.

Learning and improvement

The practice had 'buddy' arrangements with a nearby practice which included regular meetings to review issues such as referrals, A&E attendances and MMR vaccinations. The meetings were also attended by a representative from the local clinical commissioning group (CCG).

We saw records of audits and checks carried out to make sure the practice delivered high quality patient care. These included clinical learning set (CLS) audits, for example on inappropriate outpatient referrals, avoidable A&E attendances and emergency admissions. The audits summarised the action taken by the practice in the light of the audit findings. For example, in response to the A&E attendances audit the practice had taken several steps including a review of care plans following attendance particularly for frequent attenders, and a review of discharge summaries. The action taken had led to a reduction of over 15% in avoidable A&E attendances over the last year.

Identification and management of risk

The practice had appropriate risk management processes in place. These included a business continuity plan to respond to and manage risks in the event of major disruption to the service. There were regular health and safety risk assessments of the practice environment and equipment. The practice regularly monitored and reviewed risks to individual patients and updated care plans accordingly.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The service to older patients was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. There were effective arrangements to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. There were arrangements in place for engagement with other health and social care providers.

There were appropriate and effective end of life care arrangements in place. The practice participated in a number of Local Enhanced Services (LES) Direct Enhanced Services (DES) schemes to improve the management and delivery of care to specific patient groups which also covered older patients. Home visits were carried out by the GP for those who were not well enough to attend the surgery. The practice also worked closely with district nurses to support the care and treatment of housebound patients.

Our findings

Safe

There were arrangements in place to ensure patients within the over 75 population group were kept safe. There were effective arrangements to identify vulnerable and frail older patients at risk of abuse. There was access to the practice for patients with mobility difficulties.

Specific population groups were being targeted by the practice for medicines management support. The local pharmacy provided pill organiser boxes for patients aged 75 or over to assist them in administering medicines prescribed by the practice.

Caring

Care and treatment was planned to meet identified needs of patients over age 75 and was reviewed. Where patients lacked capacity the practice took account of the Mental Capacity Act 2005. There were arrangements in place to obtain patients' consent, for example because their cognitive abilities had been impaired due to the symptoms of dementia. There were appropriate and effective end of life care arrangements in place.

The practice worked in partnership with a range of external professionals to ensure integrated care pathways for patients using the service, especially those with complex needs. This included participation in a Putting Patient First local enhanced service (LES) scheme under which meetings were held monthly with district nursing and the community matron to discuss complex care planning and review patients at risk of hospital admissions.

The GP identified from patient records lists of patients for vaccinations and the receptionist phoned patients to book an appointment with the nurse. The GP also carried out screening appointments for heart disease.

Effective

There were arrangements in place to ensure the practice provided a caring service for older patients who were aged

Older people

75 years or older. Patients we spoke with in this group were complimentary about the care they received. They told us they were treated with dignity and respect and felt involved in decisions about their care and treatment.

The practice provided effective emotional support to patients receiving end of life care and bereaved relatives. There were good links with bereavement counsellors and the local palliative care team. The doctor also provided direct bereavement support and arranged additional support if needed.

Responsive

There were arrangements in place to ensure the service was responsive to the needs of older patients who were 75 years or older.

The practice participated in a number of Local Enhanced Services (LES) schemes and Direct Enhanced Services (DES) to improve the management and delivery of care to specific patient groups which also covered older patients. This included a Putting Patients First LES scheme which identified patients who may need additional care planning and a Dementia DES scheme to identify patients at risk of dementia through screening.

The practice had an Age UK primary care navigator for the over 55 age group to help patients find their way through the NHS system and provide support with wider issues such as social care, housing, and co-ordinating appointments. The practice worked closely with the district nurses who visited all housebound patients. Flu vaccinations were arranged at home with the district nursing team, who also carried out regular routine checks such as blood pressure monitoring. The practice referred older patients to the rapid response service if they were identified as being at risk of a hospital admission.

Well-led

There were arrangements in place to ensure the practice was well led for the general population which also applied to older patients.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The service to patients with long term conditions was safe, effective, caring, responsive and well led. There were safe arrangements in place to review medication for patients with long term conditions. The practice had effective arrangements to help patients manage their long term conditions. The practice took part in regular clinical learning set (CLS) audits relating to long term conditions.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups with long term conditions.

Our findings

Safe

There were arrangements in place to ensure patients with long term conditions were kept safe. Specific population groups were being targeted for medicines management support. Patients with long term conditions were given an annual medical check which included a review of medicines, for example patients with asthma had their prescribed steroids reviewed to ensure they were still suitable. The practice offered an in house spirometry service (a breathing test to assess lung function) for patients with chronic obstructive pulmonary disease (COPD).

Most COPD patients had already been provided with a COPD response pack containing a supply of standby medicines to start if their COPD got worse before they were able to see the GP. However, in response to an externally led audit the practice had taken action to ensure all COPD patients were provided with a response pack.

Caring

We found the practice had effective arrangements in place to help patients manage their long term conditions.

The practice took part in regular clinical learning set (CLS) audits relating to long term conditions for example diabetes, and musculoskeletal conditions. The practice collated its results and presented them at monthly CLS peer review meetings. The outcomes and action plans were reviewed at practice meetings.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. This ensured continuity of care for patients with long term conditions. The practice had access to a multi-disciplinary team to

People with long term conditions

support the management of diabetes and support an integrated model of care. There were monthly practice meetings with district nurses and community matrons to discuss cases.

The practice had a high number of diabetic patients (over 200) and routinely referred them to the Maida Vale diabetic centre. The practice also regularly referred diabetics to a specialist dietician for dietary advice.

Effective

There were arrangements in place to ensure the practice provided a caring service for patients with long term conditions. Patients were mostly positive about the compassion, dignity and respect they were shown.

Patients were involved in decisions about their care. We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes

Responsive

There were arrangements in place to ensure the service was responsive to the needs of patients with long term conditions. There were arrangements in place to meet the specific needs for those patients who needed additional support, for example, with communication or mobility needs.

The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups with long term conditions, for example schemes for chronic obstructive pulmonary disease (COPD) and patients with complex long-term conditions.

Patients received support from the practice following discharge from hospital. Home visits were carried out by the GP for those who were not well enough to attend the surgery. The practice also had access to Westminster rehabilitation team if the GP was unable to visit the patient. The team provides therapeutic support to avoid unnecessary admission to hospital, minimize significant risks, facilitate early hospital discharge and provide rehabilitation support for patients who had reduced independence.

Well-led

There were arrangements in place to ensure the practice was well led for the general population which also applied to people with long terms conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The service to mothers, babies, children and young people was safe, effective, caring, responsive and well led. There were effective arrangements in place to safeguard children and young people. There were arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people. Patients we spoke with told us they felt involved in making decisions about their care and treatment. Mothers we spoke with confirmed they were always asked for consent before their children were treated. There were specific services and health promotion clinics available for this population group. Special arrangements were in place to enable improved access to appointments.

Our findings

Safe

There were arrangements in place to ensure mothers, babies, children and young people were kept safe.

Mothers we spoke with during the inspection told us they felt safe at the practice. There were safeguarding policies for both children and vulnerable adults. All staff had been trained in spotting and dealing with child protection issues. The nurse practitioner had received training relating to female genital mutilation (FGM) within safeguarding training and the practice had access to a special unit and social services.

There were arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people. A health visitor attended the practice to provide support and advice to mothers, babies, children and young people.

Caring

There were arrangements in place to ensure treatment was effective for mothers, babies, children and young people.

The nursing staff were trained in smear testing and immunisation for children and adults. There was a range of health promotion information available in the reception area relevant to this population group including leaflets for about chlamydia, contraception, smoking cessation, and immunisation for children.

Effective

There were arrangements in place to ensure the practice provided a caring service for mothers, babies, children and young people.

Patients we spoke with told us they felt involved in making decisions about their care and treatment. They were given sufficient time with the doctor or nurse and were able to ask questions and discuss the treatment they received. Two mothers we spoke with said they were always involved in decisions about their children's care.

Mothers, babies, children and young people

We found, before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. When vaccinating children, if they were accompanied by a grandparent the nurse would always phone a parent to check consent. Mothers we spoke with confirmed they were always asked for consent before their children were treated.

Responsive

There were arrangements in place to ensure the practice provided a responsive service for mothers, babies, children and young people.

There were specific services and health promotion clinics available for this population group. These included daily run antenatal and post natal clinics, including six week follow up checks, a child health and immunisation clinic, family planning, pregnancy advisory service, sexual health and free condom distribution. The practice offered annual Chlamydia screening for 15-24 year olds.

Patients were able to book any available appointment, but the practice had recently started a trial of having a vaccination clinic on Wednesday afternoons to see if this reduced waiting times for children; in the past there had been poor attendance at set clinic times. The practice was also part of an extended hour's local enhanced scheme to set aside one hour a day available for emergency appointments.

Well-led

There were arrangements in place to ensure the practice was well led for the general population which also applied to mothers, babies, children and young people.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The service to working age patients (and those recently retired) was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. The practice carried out regular monitoring of individual patients to ensure care and treatment remained suited to their needs. Patients were asked for their consent to treatment and felt involved is decisions about their care. Patients received advice and guidance about making healthy life style choices. A late opening clinic was available for those patients who could not get to the surgery during regular working hours.

Our findings

Safe

There were arrangements in place to ensure working age patients (and those recently retired) were kept safe. The patients we spoke with in this population group raised no concerns about their safety in using the service.

The practice had in place arrangements to identify abuse and reduce the risk of abuse happening. The practice was able to support other agencies in dealing with issues relating to domestic violence.

Caring

There were arrangements in place to ensure the service was effective for patients of working age and those recently retired.

The practice carried out regular monitoring of individual patients to ensure care and treatment remained suited to their needs. The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure integrated care pathways for patients using the service. Staff were appropriately qualified and competent to carry out their roles safely and effectively.

All newly registering patients completed a detailed registration form which, together with an initial examination or health check, formed the basis for assessing any support of health promotion needs.

There were leaflets displayed in the waiting room for patients to access. These included information about common conditions and their symptoms, promotion of healthy lifestyles, and prevention of ill health. Patients received advice and guidance about making healthy life style choices. The service also offered smear tests to patients when needed.

Effective

There were arrangements in place to ensure the practice provided a caring service for patients of working age and those recently retired.

Working age people (and those recently retired)

Feedback from patients in this population group was positive about the way staff treated them. We observed staff being courteous and respectful towards patients both face to face and over the telephone.

Patients told us they felt involved in decisions about their care and treatment. Before they received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes.

Responsive

There were arrangements in place to ensure the practice provided a responsive service for patients of working age and those recently retired.

Patients we spoke with and those who completed comments cards were mostly happy about the appointments system. However, in response to patient feedback the practice provided late opening until 8pm one night a week. They had also started a trial of prioritising the last hour of appointments for working patients. Some patients found the waiting time when attending for an appointment unsatisfactory and the practice was reviewing this in response to the latest patient participation group patient survey.

Patients we spoke with told us they had not had any reason to make a formal complaint about the service. There were no current formal complaints under consideration and only four in the last year.

As part of a local enhanced services (LES) scheme for chronic obstructive pulmonary disease (COPD), the practice offered spirometry screening for all smokers aged over 50 and NHS checks to all patients over 40. The practice offered minor surgery at times convenient to the patient.

Well-led

There were arrangements in place to ensure the practice was well led for the general population which also applied for working age patients (and those recently retired).

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The service to patients in vulnerable circumstances who may have poor access to primary care was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. The practice regularly monitored and reviewed risks to individual patients and updated care plans accordingly. There were arrangements in place to support specific groups, for example patients with learning disabilities, drug and alcohol problems and the homeless. The practice did not have any travellers or sex workers registered. The appointments system was arranged to facilitate access for patients in this population group.

Our findings

Safe

There were arrangements in place to ensure patients in vulnerable circumstances who may have poor access to primary care were kept safe.

The practice regularly monitored and reviewed risks to individual patients and updated care plans accordingly. We were told of an audit of patients who attended the practice's drug and alcohol clinic carried out by the Westminster Shared Care Community team. The practice reviewed the audit outcomes and drew up management plans, including safeguarding for individual patients.

There were effective arrangements in place to identify vulnerable patients at risk of abuse and staff were appropriately trained in safeguarding of vulnerable adults.

Wheelchair users and patients with mobility problems were seen for both GP and nurse consultations in the nurse's room on the ground floor of the practice.

Caring

There were arrangements in place to ensure the service was effective for patients in vulnerable circumstances who may have poor access to primary care.

Under a drug and alcohol direct enhanced services (DES) scheme the practice screened all new registrations to identify patients in need of support. Patients were referred to the gym, fit for life or a weight loss programme.

The practice participated in a Putting Patient First local enhanced service (LES) under which meetings were held monthly with district nursing and the community matron to discuss complex care planning and review patients at risk of hospital admissions.

People in vulnerable circumstances who may have poor access to primary care

Effective

There were arrangements in place to ensure the practice provided a caring service for patients in vulnerable circumstances who may have poor access to primary care.

Patients for whom English was not a first language had access to an interpretation service. Staff also spoke many languages and were able to communicate effectively with many patients whose first language was not English. We saw in reception a repeat prescription sign in Bengali in response to a large proportion of practice's population who spoke this language.

The practice participated in a local enhanced services scheme to identify homeless patients and offer extra help as required, such as support letters. All patients were asked for their housing status at registration. The practice registered homeless patients but also saw any who came as walk in patients.

Responsive

There were arrangements in place to ensure the practice provided a responsive service for patients in vulnerable circumstances who may have poor access to primary care.

The practice ran a weekly drug and alcohol clinic provided by a community drugs project co-ordinator. The co-ordinator provided prescriptions which were signed by the GP. Patients with medical problems were referred to the nursing team for health checks and to the GP for acute problems. If patients required input from social services, this was discussed with the GP first before a referral was made. Patients were also referred to a local drug and alcohol rehabilitation service, or could self-refer. The co-ordinator facilitated access to local drug and alcohol services to access employment training advice, computer courses and voluntary positions.

The practice participated in a local enhanced services scheme (LES) for patients with learning disabilities. Under the scheme the practice worked with a local learning disability link nurse. The nurse visited the practice periodically to provide briefing on the Mental Capacity Act 2005 and consent issues. The practice offered annual reviews and a health action plans for all patients with a learning disability. Double appointments were arranged for patients with a learning disability at the beginning of the appointments list to avoid them becoming anxious by being kept waiting in reception.

Well-led

There were arrangements in place to ensure the practice was well led for the general population which also applied for patients in vulnerable circumstances who may have poor access to primary care.

To improve access to patient feedback processes, the practice had arranged for representatives on the patient participation group to include a patient who did not speak English and a patient with severe learning disabilities, who would otherwise not be able to offer their opinion.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The service to patients experiencing poor mental health was safe, effective, caring, responsive and well led. There were arrangements in place to ensure these patients were kept safe. The practice had effective arrangements for monitoring and reviewing patients in this population group, including their medicines. There was a multidisciplinary approach to ensure integrated care for these patients. The practice facilitated and encouraged access to mental health support and counselling services. Where patients lacked capacity, appropriate account was taken of the Mental Capacity Act 2005.

Our findings

Safe

There were effective arrangements to identify patients experiencing poor mental health at risk of abuse. There were robust arrangements for monitoring patients on high risk drugs and we were told of reviews and medicines management plans for patients on anticonvulsant and mood stabilizing drugs such as carbamazepine, lamotrigine, phenytoin and valproate. Patient records were flagged to identify when they were due for a medicines review and arrangements were made for them to attend the surgery or receive a home visit for this.

Under the Quality and Outcomes Framework (QOF) which rewarded GP practices for its level of achievement against a range of clinical and non-clinical indicators, the practice offered an annual review to patients experiencing poor mental health.

Caring

There were arrangements in place to ensure the practice provided an effective service for patients experiencing poor mental health.

The practice attended multidisciplinary team (MDT) integrated care pathway meetings monthly to consider the care management of specific patients with complex needs requiring an MDT input.

The practice facilitated patients' access to the Westminster 'Improving Access to Psychological Therapies (IAPT) programme which provided self-help courses for patients with common mental health difficulties such as stress, worry and low esteem. The practice also had links to the MIND counselling service and referred patients to this.

The practice participated in the local enhanced services (LES) scheme for patients with severe mental illness (SMI) to improve referrals and discharges from the local mental health team (MHT).

People experiencing poor mental health

Effective

There were arrangements in place to ensure the practice provided a caring service for patients experiencing poor mental health.

There were arrangements in place to secure the consent of patients who lacked capacity in line with the Mental Capacity Act 2005, involving family, carers, social services and advocates where appropriate. The practice worked with Westminster Advocacy service and referred patients to the service as needed. We were told of best interest meetings recently involving mental health professionals, social services and family carers in decision making and discussion of advice about treatment.

Carers were referred to the 'Carers Network' to access financial and social support.

Responsive

There were arrangements in place to ensure the practice provided a responsive service for patients experiencing poor mental health.

The practice attended monthly multi-disciplinary meetings which included representatives from the local mental health team and social services, the community matron and district nurses to review patients with complex mental health needs.

A mental health nurse attended the practice weekly to provide a clinic for patients experiencing mental health problems. The GP referred patients to the clinic when the need was identified.

Well-led

There were arrangements in place to ensure the practice was well led for the general population which also applied for patients experiencing mental health problems.