Dr Philip Mackney (The Elgin Clinic)

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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Philip Mackney on 24 September 2015. The overall rating for the practice was good with requires improvement for providing safe services. The full comprehensive report on the 24 September 2015 inspection can be found by selecting the 'all reports' link for Dr Philip Mackney on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 20 June 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 24 September 2015. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as requires improvement.

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

- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found the processes and management of significant events, patient safety alerts, repeat prescribing, prescription management and risk assessments required improvement.
- Staff we spoke with were aware of current evidence based guidance. However, there were no systems in place to ensure all staff were up-to-date or following guidance.
- Clinical protocols were not available to support the scope of responsibility undertaken by the healthcare assistant.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- There was no quality improvement programme and little evidence that clinical audits were driving improvements to patient outcomes.

Summary of findings

- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but some contained out-of-date information.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider must make improvement are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvement are:

- Review the infection control audit to ensure all improvements identified have been actioned and consider the infection control lead undertaking enhanced training to support them in this extended role.
- Continue to monitor patient outcomes in relation to the childhood immunisation programme.
- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Consider displaying the mission statement in a location visible to patients.

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, as there are areas where improvements need to be made.

- Although risks to patients were assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, we found the processes and management of significant events, patient safety alerts, repeat prescribing, prescription management and risk assessments required improvement.
- From the sample of documented examples we reviewed, we found that when things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology.
- Staff demonstrated that they understood their responsibilities in relation to safeguarding and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had systems and processes in place to ensure recruitment checks had been undertaken prior to employment.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements need to be made.

- Staff we spoke with were aware of current evidence based guidance. However, there were no systems in place to ensure all staff were up-to-date or following guidance.
- Clinical protocols were not available to support the scope of responsibility undertaken by the healthcare assistant.
- Data from the Quality and Outcomes Framework showed patient outcomes were, on the whole, comparable to local and national averages.
- There was no quality improvement programme and little evidence that clinical audits were driving improvements to patient outcomes.
- There was little evidence that clinical audit was driving improvement in patient outcomes.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- On the day of the inspection we saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Data from the national GP patient survey showed patients rated the practice comparable to others for several aspects of care. For example, 84% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 84%; national average 85%).
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible in the surgery and on the practice website.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. For example, 66% of patients said they usually get to see or speak with their preferred GP (CCG average 60%; national average 59%).
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from eight examples reviewed showed the practice responded quickly to issues raised. However, response letters did not include all information in line with national guidance.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services, as there are areas where improvements need to be made.

Summary of findings

- The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no written strategy or supporting business plan that detailed the short and long-term development objectives that the practice wanted to achieve.
- Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements for identifying, recording and managing risks were not implemented well enough to ensure patients were kept safe.
- The practice had a mission statement but this was not displayed in the waiting area.
- There was a leadership structure and staff told us they felt supported by management.
- Staff had received inductions and annual performance reviews.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty.

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

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. For example, the practice liaised with local pharmacies regarding dossette boxes (a pill container and organiser for storing scheduled doses of a patient's medication) and repeat dispensing for this cohort.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care. The practice utilised Coordinate My Care (CMC), a personalised urgent care plan developed to give people an opportunity to express their wishes and preferences on how and there they are treated and cared for.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. In addition, patients requiring additional support could be referred to a Primary Care Navigator who helped signpost patients to health, social care and voluntary sector services.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice held regular multi-disciplinary team meetings with district nurses, community matrons, palliative care team, social services and the mental health team to coordinate and maintain the care of this cohort.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- Performance for some diabetes related indicators was variable with some outcomes below the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 67% (CCG average 74%; national average 78%) and the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 62% (CCG average 76%; national average 78%).
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were below target for standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 75% and the national average of 81%.
- The practice offered Chlamydia testing.
- Appointments were available outside of school hours and the premises were suitable for children and babies. There were baby changing and breast feeding facilities.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement 

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, the practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement 

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice utilised Coordinate My Care (CMC), a personalised urgent care plan developed to give people an opportunity to express their wishes and preferences on how and there they are treated and cared for. We also saw that care plans were personalised.
- The practice offered longer appointments for patients with a learning disability and those requiring an interpreter.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice hosted a substance misuse clinic.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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)

Requires improvement 

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group. However, there was evidence of some good practice.

Summary of findings

- Patients at risk of dementia were identified and offered an assessment.
- The percentage of patients from a register of 65 diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 80% (CCG average 85%; national average 84%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The percentage of patients from a register of 90 with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93% (CCG average 91%; national average of 89%) and the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 84% (CCG average 89%; national average 89%).
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016 for the most recent data. Three hundred and fifty-two survey forms were distributed and 103 were returned. This represented 2.3% of the practice's patient list and a completion rate of 29%. The results showed the practice was performing above local and national averages for some aspects of patient experience. For example:

- 97% of patients found it easy to get through to the surgery by phone compared with the clinical commissioning group (CCG) average of 86% and the national average of 73%.
- 92% of patients described the overall experience of this GP practice as good compared with the CCG average of 85% and the national average of 85%.
- 79% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 77% of patients are satisfied with the surgery's opening hours compared with the CCG average of 77% and the national average of 76%.
- 78% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received six comment cards which were all positive about the standard of care received. Patients described the surgery as caring, efficient and friendly.

Results of the Friends and Family Test (FFT) for the period December 2016 to May 2017 based on 269 responses showed that 89% of patients were extremely likely or likely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service SHOULD take to improve

- Review the infection control audit to ensure all improvements identified have been actioned and consider the infection control lead undertaking enhanced training to support them in this extended role.
- Continue to monitor patient outcomes in relation to the childhood immunisation programme.
- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Consider displaying the mission statement in a location visible to patients.

Dr Philip Mackney (The Elgin Clinic)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Dr Philip Mackney (The Elgin Clinic)

Dr Philip Mackney, also known as The Elgin Clinic, operates from purpose-built premises at 40 Elgin Avenue, Westminster, London W9 3QT. The practice is on a single-level and has access to six consulting rooms.

The practice provides NHS primary care services to approximately 4,500 patients and operates under a General Medical Services (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract). The practice is part of NHS West London Clinical Commissioning Group (CCG).

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services.

The practice staff comprises of a principal GP, a male and female salaried GP (totalling 24 sessions per week), a practice nurse (0.6 whole time equivalent) and full-time healthcare assistant. The clinical team are supported by a practice manager and a team of six administration and reception staff.

The practice population is in the second most deprived decile in England. People living in more deprived areas tend to have greater need for health services. The practice has a higher than average population of male and female patients between the ages of 25 and 39 years.

The practice is open between 8.15am and 5pm on Monday, Tuesday, Wednesday and Friday and from 8.15am to 1.15pm on Thursday. Appointments are available with a doctor in the morning from 8.40am to 11.30am and in the afternoon from 2.30pm to 4pm except Thursday when the surgery is closed. The practice does not provide any extended hours services.

When the surgery is closed, out-of-hours services are accessed through the local out of hours service or NHS 111.

Why we carried out this inspection

We undertook an announced comprehensive inspection at Dr Philip Mackney (The Elgin Clinic) on 24 September 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The overall rating for the practice was good with requires improvement for providing safe services. The full comprehensive report on the 24 September 2015 inspection can be found by selecting the 'all reports' link for Dr Philip Mackney on our website at www.cqc.org.uk.

We undertook a follow-up announced comprehensive inspection of Dr Philip Mackney (The Elgin Clinic) on 20

Detailed findings

June 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 June 2017. During our visit we:

- Spoke with a range of staff which included the principal GP, salaried and locum GPs, practice nurse, healthcare assistant, practice manager and reception staff.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Inspected the facilities, equipment and premises.
- Reviewed a wide range of documentary evidence including policies, written protocols and guidelines, recruitment and training records, safeguarding referrals, significant events, patient survey results, complaints, meeting minutes and performance data.

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 24 September 2015, we rated the practice as requires improvement for providing safe services as the arrangements in respect of the availability of oxygen and safeguarding training required improvement.

Although the practice had made some improvements, at our follow-up inspection on 20 June 2017 we found additional areas of concern in relation to significant events, patient safety alerts, repeat prescribing, prescription management and risk assessments required improvement.

The practice remains rated as requires improvement for providing safe services.

Safe track record and learning

Although there was a system for reporting and recording significant events this required improvement.

- The practice had an incident management policy which had been reviewed in May 2017. The policy was not comprehensive. For example, it did not include any examples of what constituted a significant event to guide staff. Furthermore, the policy contained out of date information, for example, it referenced significant event reporting being a requirement of the Quality and Outcome Framework (QOF). The organisational indicator (Education 7) which required a practice to undertake a minimum of 12 signficant event reviews in the preceding 12 months was retired from QOF from 2013/14.
- The practice had only recorded three significant events for the past 12 months. One of the GPs told us of a significant event regarding a secondary care referral letter which the practice had failed to send. However, this had not been recorded and investigated as per the practice protocol.
- Staff told us they would inform the practice manager of any incidents who would record onto a paper significant event form. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed all documented examples and found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information and a written apology.
- The practice had not monitored trends in significant events due to the small number recorded.

The practice told us that patient safety alerts and MHRA (Medicines and Healthcare Regulatory Agency) alerts were received via email by the practice manager and disseminated to staff. However, the practice did not maintain a record to demonstrate that all alerts had been reviewed, appropriate action taken and shared with staff.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety:

- The practice had a safeguarding children and safeguarding adult policy which were available to staff. We noted that both policies, which had been reviewed in May 2017, referenced throughout the Primary Care Trust (PCT) which were nationally abolished in 2013 and replaced by clinical commissioning groups (CCGs). The policies were generic and did not reference current guidance on topics such as the mandatory reporting of female genital mutilation (FGM) or preventing violent extremism. However, we did note that clinical and non-clinical staff had completed on-line Prevent (preventing violent extremism) training.
- The practice had a safeguarding children and adult lead and deputy lead. These were referenced in the safeguarding children policy but not the safeguarding adult policy. Staff we spoke with knew who the leads were. The practice locum GP information pack did not reference safeguarding or include relevant contact numbers.
- GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies. The practice held monthly multi-disciplinary meetings which included the health visitors.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child safeguarding level three, the healthcare assistant to level two and administration staff to level one.

- Notices in the practice advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff we spoke with who acted as a chaperone demonstrated that they understood their role and confirmed they had received training.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There was a cleaning schedule and monitoring system in place.
- The practice nurse, who worked three days a week, was the infection prevention and control (IPC) clinical lead with support from the healthcare assistant. We saw that both had received on-line IPC training undertaken by all staff but neither had undertaken any enhanced training to support the responsibilities of the lead role.
- There was an IPC policy available but this was not comprehensive and did not include reference to standard precautions, for example, hand washing and protective clothing. There was a separate protocol for needle stick injuries, clinical waste management and Control of Substances Hazardous to Health (COSHH). The COSHH policy referenced that a COSHH risk assessment would be undertaken on an annual basis and that safety data sheets (a document that provides health and safety information about products, substances or chemicals that are classified as hazardous substances) were maintained by the practice. However, these were not available. After the inspection the practice forwarded a COSHH risk assessment it had undertaken for its cleaning products.
- An IPC audit had been undertaken in May 2017 by the healthcare assistant. However, there was no action plan to evidence that action had been taken to address the improvements identified. We noted that although the IPC audit reviewed clinical waste procedures it had not alerted the practice to the fact that clinical staff did not have access to all the appropriate colour-coded sharps containers required for the range of medicines administered.
- All staff we spoke with knew the location of the bodily fluid spill kits and had access to appropriate personal protective equipment when handling specimens at the reception desk.
- We observed that each consulting room had information displayed on good handwashing techniques, how to deal with a sharps injury and was well equipped with personal protective equipment and waste disposal facilities.

Although there were arrangements in place for managing medicines, including emergency medicines and vaccines to minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal) these required improvement.

- The practice did not have effective processes in place to manage repeat prescribing. We found that not all patients on repeat prescribing had a medication review date in their clinical records and prescriptions were issued after the authorised number of prescriptions had been exceeded. In addition, there were no formal processes in place for the management of high risk medicines such as warfarin, methotrexate and other disease-modifying anti-rheumatic drugs (DMARDs) in line with guidance. For example, the practice did not have a mechanism in place to check patients had up-to-date blood tests, in particular those undertaken in the secondary care setting, before repeat prescriptions were issued.
- Blank prescription forms and pads not in use were stored in a locked cupboard. However, there was no system in place to track their use in line with guidance.
- There were dedicated vaccine storage refrigerators with built-in and secondary thermometers. We saw evidence that the minimum, maximum and actual temperatures were recorded daily.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that these were signed and dated by the practice nurse.

We reviewed four personnel files, which included a locum GP, and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Requires improvement

Are services safe?

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and a health and safety poster in the reception back office.
- The practice had an external contract in place for the maintenance of the fire detection and warning system and fire extinguishers. There was a fire policy and up-to-date fire risk assessment in place. The practice carried out regular fire drills and had nominated a designated fire marshal. All staff had been trained in fire awareness and staff we spoke with confirmed there had been a recent fire evacuation drill and they all knew the location of the fire assembly point.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had undertaken a Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) risk assessment and a risk assessment for a pregnant employee working within the practice premises. However, the practice had not undertaken a premises or health and safety risk assessment.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. At the time of our inspection the practice had a GP on maternity leave and was covering the clinical sessions with a locum GP.

Arrangements to deal with emergencies and major incidents

- There were some emergency medicines available in the practice which were kept in a secure area, regularly checked and were within their expiry date. However, we found that the practice had not undertaken a formal risk assessment to support its decision not to have available aspirin for suspected myocardial infarction, an anti-emetic for nausea and vomiting, hydrocortisone for injection for acute severe asthma, chlorphenamine for injection for anaphylaxis or acute angio-oedema and benzylpenicillin for injection for suspected bacterial meningitis. The practice told us that its decision not to stock these medicines was based on the surgery being located in central London with good ambulance response times and situated opposite a community pharmacy where the medicines could be easily obtained. Although on the day of the inspection the practice demonstrated they could acquire from the community pharmacy a number of emergency medicines we found that benzylpenicillin for injection and chlorphenamine for injection were not available and had to be ordered. The practice sent evidence the day after the inspection that these had been delivered and had updated its emergency drugs protocol to reflect its current stock of emergency medicines.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. All staff we spoke with knew where they were located. We saw that all staff had received annual basic life support training.
- A first aid kit and accident book were available and staff we spoke with knew where these were.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice had established a 'buddy' system with a neighbouring practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 24 September 2015, we rated the practice as good for providing effective services. However, at our follow up inspection on 20 June 2017 we found that systems and processes to ensure staff were up-to-date with relevant and current evidence based guidance and clinical protocols to support the role of the healthcare assistant required improvement.

The practice is now rated as requires improvement for providing effective services.

Effective needs assessment

Clinicians we spoke with on the day were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. However:

- The practice did not have an effective system in place to ensure all clinical staff were up- to-date. The principal GP told us he relied on GPs keeping themselves up-to-date.
- The practice did not have a system to monitor that these guidelines were followed. For example, through risk assessments, audits and random sample checks of patient records.
- We saw that the healthcare assistant had been trained to undertake some out of hospital services, for example, electrocardiograms (ECGs) and spirometry. However, clinical protocols were not available outlining the framework for the management of all clinical situations within their scope of responsibility.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 90% of the total number of points available (CCG 91%; national 95%) with 4% overall exception reporting (CCG 6%; national average 6%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was, on the whole, statistically comparable with local and national averages for QOF clinical targets. Data from 2015/16 showed:

Performance for some diabetes related indicators was variable with some outcomes below the CCG and national averages. For example:

- The percentage of patients with diabetes, on the register, in whom the last HbA1c was 64 mmol/mol or less in the preceding 12 months was 67% (CCG average 74%; national average 78%) with a practice exception reporting of 8% (CCG average 12%; national 12%);
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 62% (CCG average 76%; national average 78%) with a practice exception reporting of 5% (CCG average 9%; national average 9%);
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 71% (CCG average 76%; national average 80%) with a practice exception reporting of 9% (CCG average 11%; national average 13%).

Performance for mental health related indicators was statistically comparable to the CCG and national averages. For example:

- The percentage of patients from a register of 90 with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93% (CCG average 91%; national average of 89%) with a low practice exception reporting of 2% (CCG average 9%; national average 13%);
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 84% (CCG average 89%; national average 89%) with a low practice exception reporting of 2% (CCG average 7%; national average 10%);
- The percentage of patients from a register of 65 diagnosed with dementia who had had their care reviewed in a face-to-face meeting in the last 12 months was 80% (CCG average 85%; national average 84%) with a practice exception reporting of 9% (CCG average 7%; national average 7%).

Requires improvement

Are services effective?

(for example, treatment is effective)

Performance for respiratory-related indicators was statistically comparable to the CCG and national averages. For example:

- The percentage of patients with asthma, on its register of 236 patients, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control was 75% (CCG average 77%; national average 76%) with a practice exception reporting of 3% (CCG average 4%; national average 8%);
- The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness was 95% (CCG average 88%; national average 90%) with a practice exception reporting of 18% (CCG average 11%; national average 12%);
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 94% (CCG average 95%; national average 95%) with a practice exception reporting of 0.3% (CCG average 1.2%; national average 0.8%).

There was no quality improvement programme and little evidence that clinical audits were driving improvements to patient outcomes. The practice had participated in two CCG-led single-cycle prescribing audits identifying patients on domperidone (a drug used to control nausea and vomiting) to ensure prescribing was in line with guidance and vitamin D to ensure patients were on correct dose. The practice could not provide any other evidence of clinical audit.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions had undertaken diabetes, asthma and chronic obstructive pulmonary disease (COPD) updates.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.
- The learning needs of staff were identified through a system of appraisals. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. However, none of the clinical staff we spoke with had undertaken formal MCA training.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were signposted to the relevant service.
- A smoking cessation advisor was available in the practice two mornings per week.
- A Primary Care Navigator was attached to the practice and could help signpost patients to health, social care and voluntary sector services. This service was accessible in the surgery or at a patient's/carer's home if required.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 75% and the national average of 81%. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Childhood immunisation rates for the period 1 April 2015 to 31 March 2016 for the vaccinations given to the under two year olds were below the national average. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice achievement ranged from 72% to 82%. These measures can be aggregated and scored out of 10, with the practice scoring 7.6 (compared to the national average of 9.1). Immunisation rates for five year olds were between 83% and 93% (CCG 62% and 83%; national average 88% and 94%). The practice actively recalled patients through letters and its text messaging service. Current unvalidated childhood immunisation data provided by the practice on the day of the inspection showed take-up rates were increasing.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

At our previous inspection on 24 September 2015, we rated the practice as good for providing caring services. At our follow up inspection on 20 June 2017 we also found the practice was good for providing caring services.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.

All of the six patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was rated as comparable to other for its satisfaction scores on consultations with GPs and nurses. For example:

- 83% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 87% of patients said the nurse was good at listening to them compared with the CCG average of 87% and the national average of 91%.
- 90% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Feedback indicated that patients felt involved in decision making about the care and treatment they received, felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

The practice utilised Coordinate My Care (CMC), a personalised urgent care plan developed to give people an opportunity to express their wishes and preferences on how and there they are treated and cared for. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 82% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 90%.

Good

Are services caring?

- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation 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 practice website had the functionality to translate to other languages and the patient check-in screen was available in other languages aligned to the practice demographic.
- Information leaflets were available in easy read format and there was a health information tv screen in the waiting room and on the practice website.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Patients over 55 years of age requiring support could be referred to a Primary Care Navigator who was attached to the practice and could help signpost patients to health, social care and voluntary sector services. This service was accessible in the surgery or at a patient's/carer's home if required.

Information was available to direct carers to the various avenues of support available to them which included details within the surgery of the local carer's network and signposting through the Primary Care Navigator. The practice had worked with the Carer's Network to raise awareness. The practice's computer system alerted GPs if a patient was also a carer. The practice had currently only identified 19 patients as carers (0.4% of the practice list).

Staff told us that if families had experienced bereavement, their usual GP would contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 24 September 2015, we rated the practice as good for providing responsive services. At our follow up inspection on 20 June 2017 we also found the practice was good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- There were longer appointments available for patients with a learning disability and those requiring an interpreter.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The practice was easily accessible to patients and all services were provided on the ground floor.
- The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms and was visible from reception. There was enough seating for the number of patients who attended on the day of inspection.
- Patients had access to baby changing and breast feeding facilities.

Access to the service

The practice was open between 8.15am and 5pm on Monday, Tuesday, Wednesday and Friday and from 8.15am to 1.15pm on Thursday. The principal GP told us that he answered and triaged patient calls to the surgery between 5pm and 6.30pm. Appointments were available with a doctor in the morning from 8.40am to 11.30am and in the afternoon from 2.30pm to 4pm except Thursday when the surgery was closed.

The practice does not provide any extended hours services.

In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments and telephone consultations were also available for patients that needed them. Patients were able to book appointments on-line and there was an appointment text reminder system in operation.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above the local and national averages for some responses. For example:

- 97% of patients said they could get through easily to the practice by phone compared to the CCG average of 86% and the national average of 73%.
- 96% of patients said their last appointment was convenient compared with the CCG average of 91% and the national average of 92%.
- 66% of patients said they usually get to see or speak with their preferred GP compared to the CCG average of 60% and the national average of 59%.
- 77% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 84% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 79% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 57% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Good

Are services responsive to people's needs?

(for example, to feedback?)

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- There was a complaint policy in place which, although reviewed in May 2017, referenced the Primary Care Trust (PCT) which were nationally abolished in 2013 and replaced by clinical commissioning groups (CCGs).
- The practice manager and principal partner were the designated responsible individuals who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, posters and a patient complaint form which outlined guidance for patients in line with contractual obligations for GPs in England. For example, how to contact the Parliamentary Ombudsman.

The practice had recorded eight complaints in the past 12 months and we found these had been handled satisfactorily and in a timely manner. We saw evidence of apology letters to patients. We saw evidence that learning outcomes were discussed in practice meetings.

Are services well-led?

Requires improvement

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

Our findings

At our previous inspection on 24 September 2015, we rated the practice as good for providing well-led services. At our follow up inspection on 20 June 2017 we found that the overarching governance framework was not implemented well enough to ensure patients were kept safe.

The practice is now rated as requires improvement for providing well-led services.

Vision and strategy

The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. However, there was no written strategy or supporting business plan that detailed the short and long-term development objectives that the practice wanted to achieve. The practice had a mission statement but this was not displayed in the waiting area. All staff we spoke with were aware of the practice values.

Governance arrangements

Although the practice had an overarching governance framework which supported the delivery of good quality care, we found some arrangements for identifying, recording and managing risks were not implemented well enough to ensure patients were kept safe. For example:

- Although there was a system for reporting and recording significant events, there was limited use of the system, not all significant events had been captured and the policy was out-of-date.
- There was no formal process in place to track patient safety alerts received and to ensure they had been reviewed, appropriate action taken and shared with staff.
- There were no effective systems in place to monitor repeat prescribing which included high risk medicines in line with guidance.
- The management of blank prescription stationery was not in line with guidance.
- There were no risk assessments in relation to premises and health and safety.
- There was no quality improvement programme and little evidence that clinical audits were driving improvements to patient outcomes.
- Some practice policies and procedures contained out-of-date guidance and information.

However, we saw that the practice had structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- A comprehensive understanding of the performance of the practice was maintained.

Leadership and culture

The principal GP and practice manager told us they prioritised safe, high quality and compassionate care. Staff told us GPs and the manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The practice encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice reviewed and responded to comments made through NHS Choices.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- The practice held clinical and non-clinical staff meetings which the majority of staff said were quarterly. Although minutes were kept of these meetings they were not comprehensive and would not give adequate enough information if read by someone who had not been able to attend the meeting.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff told us they felt respected, valued and supported by the GPs and the practice manager.

Are services well-led?

Requires improvement

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

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- The NHS Friends and Family test, complaints, compliments and NHS Choices.
- The patient participation group which had recently reformed.
- Staff through meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The practice team took part in local pilot schemes to improve outcomes for patients in the area. For example, the out of hospitals services initiative which enabled patients to access various services in the primary care setting which included electrocardiogram (ECG) and spirometry.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider was failing to ensure that care and treatment was provided in a safe way for patients: • There were no effective systems in place to monitor repeat prescribing which included high risk medicines in line with guidance. • There were no effective systems in place to ensure clinical staff were up-to-date with or following current evidence-based guidance. • Clinical protocols were not available to support the scope of responsibility undertaken by the healthcare assistant. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider was failing to ensure systems and processes are operated effectively to improve the quality and safety of services: • The significant events process did not ensure all incidents were recorded and investigated and there were no review systems in place to identify and address trends.

This section is primarily information for the provider

Requirement notices

- There was no formal process in place to track patient safety alerts received and to ensure they had been reviewed, appropriate action taken and shared with staff.
- The management of blank prescription stationery was not in line with guidance.
- The practice had not undertaken risk assessments in relation to premises and health and safety.
- There was no quality improvement programme and little evidence that clinical audits were driving improvements to patient outcomes.
- Some practice policies and procedures contained out-of-date guidance and information.
- There was no written strategy or supporting business plan that detailed the short and long-term development objectives.

Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.