

The Surgery - Dr Das and Partners

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?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	10
Areas for improvement	10

Detailed findings from this inspection

Our inspection team	12
Background to The Surgery - Dr Das and Partners	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	14
Action we have told the provider to take	30

Overall summary

Letter from the Chief Inspector of General Practice

The Surgery – Dr Das and Partners provides primary medical services to approximately 2900 patients in the Fulham area of West London. This is the only location operated by this provider.

We visited the practice on 9 October 2014 and carried out a comprehensive inspection of the services provided.

We rated the practice as ‘Good’ for the caring, responsive and well-led domains; and as ‘Requiring Improvement’ under the safe, and effective domains and for all six population groups: 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; and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice worked in collaboration with other health and social care professionals to support patients’ needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice understood the needs of its patients and was responsive to these. It recognised the needs of different groups in the planning of its services.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

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

Summary of findings

Importantly, the provider must:

- Take steps to ensure patients are fully protected from the risks of unsafe or inappropriate care and treatment by the accurate maintenance of records about staff employed to carry out the regulated activities.
- Ensure patients are fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post.

In addition the provider should:

- Put in place a formal protocol for sharing information with staff and a documented process to show the practice has discussed, reviewed and agreed any action from patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE).
- Include in the procedure for reporting, recording and monitoring significant events a process for communicating the outcome and learning to relevant staff and document evidence of the dissemination of findings and follow up action within the practice.
- Put in place a policy for safeguarding vulnerable adults and ensure all staff receive relevant training.
- Ensure the practice's chaperone policy is prominently displayed and clearly communicated to patients.

- Display signs to indicate a CCTV system is in use and ensure with the landlords of the premises that it is registered with the Information Commissioners Office (ICO).
- Ensure the prescription collection box at the reception desk is not left unattended. Staff should double check the patient's address and date of birth when handing them their prescription.
- As there was only one thermometer for the vaccines fridge, consider carrying out a monthly check of the thermometer to confirm that the calibration is accurate, in line with Public Health England guidance 'Protocol for ordering, storing and handling vaccines (March 2014)'.
- Ensure the vaccine fridge was not overstocked, to avoid inhibiting air flow and circulation.
- Undertake more effective monitoring and review of the outcome of clinical audits, by further audit to test their effectiveness, to ensure the completion of the full audit cycle.
- Ensure there is documented evidence to confirm that the lessons learned from complaints have been communicated throughout the practice.
- Review practice policies and procedures in a systematic way to ensure they remain up to date and relevant.

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?

The practice is rated as requires improvement for providing safe services. Risks to patients were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. There was no formal protocol for information sharing within the practice and no documented process showing how the practice discussed, reviewed and agreed any action from external alerts and guidelines. The procedure for reporting, recording and monitoring significant events did not include a process for communicating the outcome and learning to relevant staff and we did not see documented evidence of the dissemination of findings and follow up action within the practice. The practice was unable to provide evidence of child protection training for all clinical and other staff in line with national guidance. The practice did not have a policy for the safeguarding of vulnerable adults and staff had not received training in this area. The chaperone policy was not on display in the reception or consultation rooms. There were no signs to indicate a CCTV system was in use and the practice was unable show the system was registered with the Information Commissioners Office (ICO). The vaccine fridge did not have two thermometers which is recommended under national guidance, and was slightly overstocked which may inhibit air flow and circulation. The prescription collection box at the reception desk was occasionally left unattended for short periods. Some patients were handed their prescription without staff double checking their address and date of birth. The practice was unable to provide evidence of up to date training in infection control for all relevant staff. The practice was unable provide records of the Hepatitis B immunisation status for two clinical staff. There was not a robust recruitment policy and procedure in place, particularly with regard to pre-employment checks. The practice did not have a record of criminal records checks for all staff who required them.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services. The practice participated in clinical audit and routinely collected information about patient care and outcomes. However, we did not see evidence of how the action from audits had been monitored and reviewed by further audit to test its effectiveness and complete the full clinical audit cycle. There were arrangements in place to support staff appraisal, learning and professional development. However, the practice was unable to show us

Requires improvement



Summary of findings

evidence of appraisals for all GPs, undertaken as part of their revalidation and there was no overall practice co-ordination of the completion of the revalidation process. The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment. The practice promoted good health and prevention and provided patients with suitable advice and guidance. The practice offered a full range of immunisations for children. The percentage receiving a vaccination was above the average within the CCG area for vaccinations in the 12 month age group, but below the average for the majority of vaccinations in the 24 months and five years age groups.

Are services caring?

The practice is rated as good for providing caring services. Data showed patients rated the practice above average for several aspects of care. 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 this during the inspection and saw that confidentiality was maintained. Patients were involved in decisions about their care. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The practice provided appropriate support for end of life care and patients and their carers received good emotional support. The practice was proposing a joint reception with the other GP practice on the premises but had there had been no risk assessment of these plans to ensure any risks to patient confidentiality and security of records were identified and mitigated.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice understood the needs of its patients and was responsive to these. The practice had recognised the needs of different groups in the planning of its services. The practice had participated in local enhanced services (LES) and direct enhanced services (DES) schemes to improve the management and delivery of care to specific patient groups. National data showed the practice was rated above average for the majority of indicators relating to accessibility of appointments. In response to patient feedback the practice had extended opening hours, added four new emergency slots within each GP session, introduced GP monitoring of consultation times and built in additional 'catch-up' slots for GPs. The practice learned from patient experiences, concerns and complaints to improve the quality of care. There was an accessible complaints system. Learning points were identified and acted upon but we did not see

Good



Summary of findings

documented evidence to confirm that the outcome of complaints was formally communicated throughout the practice. The premises and services had been adapted to meet the needs of people with disabilities.

Are services well-led?

The practice is rated as good for being well-led. The practice aims were set out in the practice statement of purpose. Although not all staff were aware of the statement, they were able to articulate the essence of these aims and it was clear that patients were at the heart of the service they provided. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice held weekly clinical governance meetings. There were appropriate risk management processes in place. The practice had a number of policies and procedures to govern activity. However, these were not reviewed systematically but on an ad hoc basis in response to changes. Staff had received induction training, regular performance reviews and attended regular staff meetings. The practice proactively sought feedback from staff and patients including a patient participation group (PPG). Feedback from national patient surveys was acted on but the results were not always communicated to staff.

Good



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 practice is rated as requires improvement in the key questions of Safe and Effective. The concerns which led to these ratings apply to everyone using the practice, including this population group, older people. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. There were effective risk assessment processes in place to identify patients over age 75 at risk of hospital admission and the practice had put in place risk management plans as part of their care planning. Home visits were carried out for older patients who were not well enough to attend the surgery. The practice worked closely with district nurses to support the care and treatment of elderly, housebound patients. There were also arrangements in place for engagement with other health and social care providers. The practice referred patients with complex needs to a local clinical commissioning group (CCG) network-based 'Virtual Ward' and a multidisciplinary older people's rapid access (OPRAC) service for assessment and treatment. There were appropriate and effective end of life care arrangements in place.

Requires improvement



People with long term conditions

The practice is rated as requires improvement in the key questions of Safe and Effective. The concerns which led to these ratings apply to everyone using the practice, including this population group, people with long term conditions. There were arrangements in place to review medication for patients in this group, including regular monitoring in line with national guidance. The practice carried out monthly reviews of patients on long term condition registers to identify patients at risk of sudden deterioration in health. The practice provided clinics for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Care plans had been introduced to care for people with long-term conditions. The practice proactively encouraged diabetic patients to manage their own care, for example, by giving training to check blood sugar levels and providing dietary advice and information on healthy eating and referral to a dietician for additional support where appropriate. Flu and pneumococcal vaccinations were offered to patients in at risk groups (including patients with long term conditions). For patients with long term conditions home visits were available and longer appointments provided when needed.

Requires improvement



Summary of findings

Families, children and young people

The practice is rated as requires improvement in the key questions of Safe and Effective. The concerns which led to these ratings apply to everyone using the practice, including this population group, families, children and young people. The practice undertook child health surveillance and met quarterly with health visitors to review children on the practice's caseload. There were effective follow up procedures in place for vulnerable patients who did not attend appointments, including children on the 'at risk register'. The practice provided contraception and sexual health services including contraception advice and emergency contraception, smear testing and chlamydia screening. The practice offered a full range of immunisations for children. The percentage receiving a vaccination at the practice was above the average within the CCG area for vaccinations in the 12 month age group, but below the average for the majority of vaccinations in the 24 months and five years age groups. Human Papilloma Virus (HPV) vaccination was offered to girls aged 12 to 18. Flu vaccination was offered to pregnant women. The practice ran ante natal, post-natal and baby clinics, including a joint clinic with health visitors for six-eight week baby checks. There was a fast access service for babies to see a GP. There were procedures in place to safeguard children and young people. The practice provided support to families experiencing domestic disputes. However, the practice was unable to provide evidence of child protection training for all clinical and other staff in line with national guidance.

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as requires improvement in the key questions of Safe and Effective. The concerns which led to these ratings apply to everyone using the practice, including this population group, working-age people (including those recently retired and students). The practice was accessible to working people. For example, appointments were available early morning on Tuesday and for a two-hour surgery on Saturday mornings. In addition, the practice offered telephone consultations and online booking for this group. The practice offered a full range of health promotion and screening which reflected the needs for this age group. Risk calculations were made for patients aged over 30 with a strong risk of cardiovascular disease and incorporated into care planning. All patients in the 45-74 age group were offered a health check. The practice ran regular women and men's health clinics and health and exercise advice was given at routine appointments. All women between age 47 and 73 were invited for breast screening every three years. All

Requires improvement



Summary of findings

men and women aged 60 to 69 were offered bowel screening every two years. Flu vaccination was offered to patients over the age of 65. Meningitis C vaccinations were offered to all new university students registering with the practice.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement in the key questions of Safe and Effective. The concerns which led to these ratings apply to everyone using the practice, including this population group, people whose circumstances may make them vulnerable. The practice was accessible to vulnerable groups such as homeless patients and street sex workers. Such patients could register temporarily or permanently. Annual health checks were provided for patients with learning disabilities and all seven on the register had received a check in the last 12 months. Nursing staff used sign language and drawings in communicating with patients with learning disabilities about their treatment. There were effective follow up procedures in place for vulnerable patients who did not attend appointments. Staff knew how to recognise signs of abuse in vulnerable adults and children and who to contact in the event of any safeguarding concerns. However, the practice did not have a policy for the safeguarding of vulnerable adults and staff had not received training in this area.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement in the key questions of Safe and Effective. The concerns which led to these ratings apply to everyone using the practice, including this population group, people experiencing poor mental health (including people with dementia). The practice participated in a local enhanced service scheme to deliver a shift in care from acute mental health services to community and primary care settings. The practice made regular use of a telephone psychiatry hot-line to a consultant for psychiatric advice. In addition the practice facilitated patients' access to the local 'Improving Access to Psychological Therapies (IAPT) programme. The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. The practice opportunistically screened patients at risk of dementia and referred them to a memory clinic if appropriate. The practice had arrangements in place to manage lithium therapy, a treatment for mental health problems, including bipolar disorder. There were effective follow up procedures in place for vulnerable patients who did not attend appointments, including patients with mental health problems.

Requires improvement



Summary of findings

What people who use the service say

We received 44 completed Care Quality Commission (CQC) comments cards providing feedback about the service. We also spoke with seven patients and two representatives of the practice's patient participation group (PPG) on the day of our inspection. The majority of patients were positive about the service experienced. Patients said they felt the practice offered a pleasant service and staff were helpful, supportive and caring. They said staff treated them with dignity and respect, listened to them and met their needs. They also liked the quality of the practice premises and felt they were treated in a safe, clean and comfortable environment. Six patients' comments were less positive and these were mainly about difficulty getting an appointment. In addition three patients raised issues about slow or unclear diagnoses.

Members of the PPG we spoke with supported the idea of a having a PPG. We looked at the patient survey of 75 patients conducted through the group for 2013–2014. We saw the practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of the feedback from the survey. These included the introduction of an online booking system for appointments and for requesting repeat prescriptions, earlier surgery opening at 7.00am on Tuesdays, and the provision of additional services from the premises including a weekly smoking cessation clinic and physiotherapy services.

Areas for improvement

Action the service **MUST** take to improve

- The practice was unable to provide documentary evidence of: child protection training for two of the partner GPs and a locum GP; of the Hepatitis B status for the locum doctor and the practice nurse; infection control training for three of the GPs and a locum doctor; and appraisals completed for two of the GPs. The practice must take steps to ensure patients are fully protected from the risks of unsafe or inappropriate care and treatment by the accurate maintenance of records about staff employed to carry out the regulated activities. (Regulation 20(1)(b)).
- Patients were not fully protected against all the risks associated with the recruitment of staff because not all appropriate pre-employment checks, including references and criminal records check had been carried out or recorded. (Regulation 21(a) and (b)).

Action the service **SHOULD** take to improve

- The practice kept up to date with patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). However, the practice should put in place a formal protocol for

sharing this information with staff and a documented process to show the practice has discussed, reviewed and agreed any action from external alerts and guidelines.

- The procedure for reporting, recording and monitoring significant events should include a process for communicating the outcome and learning to relevant staff and the practice should document evidence of the dissemination of findings and follow up action within the practice.
- The practice should put in place a policy for safeguarding vulnerable adults and ensure all staff receive relevant training.
- Although a chaperone policy was in place, there was no information on display to patients about this and none of the patients we spoke with were aware of the policy. The practice should ensure the policy is prominently displayed and clearly communicated to patients.
- Signs should be put on display to indicate a CCTV system is in use and the practice should ensure with the landlords of the premises that it is registered with the Information Commissioners Office (ICO).

Summary of findings

- The practice should ensure the prescription collection box at the reception desk is not left unattended. Staff should double check the patient's address and date of birth when handing them their prescription.
- Arrangements were in place to ensure the designated medicines fridge maintained the correct temperature for the storage of immunisations and travel vaccines. However, the fridge in use was not equipped with two thermometers which is recommended under Public Health England guidance 'Protocol for ordering, storing and handling vaccines (March 2014)'. The practice should consider carrying out a monthly check of the thermometer to confirm that the calibration is accurate, in line with the national guidance;
- The practice should also ensure the vaccine fridge was not overstocked, to avoid inhibiting air flow and circulation.
- The practice participated in clinical audit and routinely collected information about patient care and outcomes. However, the practice did not demonstrate it had reviewed whether care had improved by repeating clinical audits. The practice should undertake more effective monitoring and review of the outcome of clinical audits, by further audit to test their effectiveness and ensure the completion of the full audit cycle.
- The practice should ensure there is effective co-ordination of the completion of GP revalidation and evidence of related appraisals is fully documented.
- Learning points were identified and acted upon from complaints but the practice should ensure there is documented evidence to confirm that the lessons learned had been communicated throughout the practice.
- The practice should review practice policies and procedures in a systematic way to ensure they remain up to date and relevant.

The Surgery - Dr Das and Partners

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, a practice specialist, and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP, practice specialist and expert by experience were granted the same authority to enter the practice as the CQC inspector

Background to The Surgery - Dr Das and Partners

The Surgery – Dr Das and Partners is a single location GP service which provides primary medical services through a General Medical Services (GMS) contract to approximately 2900 patients in the Fulham area of West London. The practice shares premises with another GP Practice at the Bridge House Centre for Health, just off Wandsworth Bridge Road. The patient population includes a cross-section of socio-economic and ethnic groups. The practice serves a young population group with patients predominantly in the 20 to 34 years age range.

The practice team is made up of three GP partners, the practice manager who is also a partner, the practice development manager, a salaried GP and a locum GP, a

practice nurse, an agency nurse, an assistant practice manager, and two reception staff. There are three male and two female GPs (including the locum), one female practice nurse and one female agency nurse.

Opening hours are between 07:00 – 19:00 Monday to Friday and Saturday 08:00am – 10:00am. Appointments are available from 09:30-12:00 and 16:30-19:30 Monday, Tuesday and Thursday; 10:00-12:00 and 16:30-19:30 Wednesday and Friday; and 08:00-10:00 on Saturdays. Telephone access is available during opening hours and the practice has an online appointment and repeat prescription request facility. Home visits are provided for patients who are housebound or are too ill to visit the practice.

The practice has out of hours (OOH) arrangements in place with an external provider and patients are advised that they can also call the 111 service for healthcare advice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with Hammersmith and Fulham Clinical Commissioning Group (CCG), NHS England and Healthwatch. We carried out an announced visit on 9 October 2014.

During our visit we spoke with a range of staff including two GPs, the registered manager, the practice nurse, practice manager and assistant practice manager and two reception staff. We spoke with seven patients who used the service and two representatives of the practice's patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed 44 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed information that had been provided to us prior to and 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?

Our findings

Safe track record

The practice had a range of 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.

The practice kept up to date with patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). GPs also routinely used an online encyclopaedia of medicine that provided a continuously updated reference resource for clinicians. One of the partner GPs or the practice manager emailed NICE guidance to the practice medical team. The practice manager emailed patient safety alerts to the team. However, there was no formal protocol for information sharing and no documented process showing how the practice, discussed, reviewed and agreed any action from external alerts and guidelines.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff including receptionists, administrators and nursing staff were aware of the process to follow. The practice kept records of significant events and a summary of these was made available to us for events that had occurred during the last 12 months. These records provided a summary of the event, the action taken and the learning outcomes. We reviewed the practice's procedure for handling significant events and saw the form used to report events which included a description of the event, the impact on the patient, how it affected the practice and action taken and a review date recorded. However, the procedure did not include a process for communicating the outcome and learning to relevant staff. We were told that any significant events would be discussed at practice meetings. However, such events were not a permanent item on the agenda of these meetings and we did not see documented evidence of the dissemination of findings and follow up action within the practice.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding policy in place for children, including contact details for local child protection agencies. The contact details were on display and easily accessible throughout the practice. The practice had a nominated GP lead for safeguarding of children. All staff we spoke with knew who the child protection lead was, how to recognise signs of abuse and the process to follow if they suspected abuse. A log containing staff training records for medical, nursing and administrative staff was made available to us before the inspection. We also examined staff records during the inspection which included certificates of training completed. The training records indicated that the majority of staff had completed up to date child protection training. Administrative staff were trained at Level 1, nursing staff Level 2 and GPs at Level 3 in accordance with national guidance. However, the practice was unable to provide documentary evidence of training for two of the partner GPs and a locum GP. In addition, one member of the administrative team had not undertaken child protection training since March 2009.

The practice did not have an equivalent policy for the safeguarding of vulnerable adults and staff had not received training in this area. Staff did, however, show an understanding of signs of abuse and had details of local authority contacts in the event of any safeguarding concerns. In addition, two of the GP partners had recently undertaken practice based training in dementia and one of them had also undertaken mental health training.

Although a chaperone policy was in place, there was no information on display to patients about this and none of the patients we spoke with were aware of the policy. However, clinical staff told us that they would offer patients a chaperone where appropriate. The chaperone policy contained guidelines to help decide if a chaperone was needed, who could act as, and the role of a chaperone, and confidentiality requirements. It was strongly recommended in the policy that chaperones should be clinical staff and if such staff were not available the examination should be deferred. However, if suitable clinical staff were not available to act as a chaperone, some of the receptionists occasionally undertook this role. Staff we spoke with understood their responsibilities when acting as chaperones. All medical staff and staff acting as chaperones present during intimate or personal examinations had undergone a criminal records check.

Are services safe?

Medicines management

The practice had up-to-date medicines management policies in place. There was a kit containing emergency medicines and we saw that these were regularly checked and were in date. There was a clear policy for ensuring that medicines were kept at the required temperatures. The practice staff followed the policy and we saw evidence that the fridge temperature had been checked daily. However, the fridge in use did not have two thermometers which is the ideal under national guidance. The guidance advises if only one thermometer is used, then a monthly check should be considered to confirm that the calibration is accurate. The fridge was also slightly overstocked which may inhibit air flow and circulation. We discussed this with the practice and they undertook to take immediate action to reduce the overstocking by transferring some of the stock to a second fridge, which was available but not in use on the day of the inspection. The practice undertook regular cold chain audits and we saw the reports for July and September 2014. We noted the practice had acted on the latest agreed action to rotate stock to ensure the medicines closest to expiry date were used first.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. The practice used a computerised repeat prescription service. Patients could ask for a repeat prescription: by calling into the surgery when the reception was open; by post; or by using an online prescription request form. Patients were asked to allow at least 48 hours before collection. The pharmacy supplier picked up prescriptions and delivered medicines to housebound, elderly and vulnerable patients. Periodically, patients were asked to see their doctor to review their medication. We saw the alert system on the practice's computer system for six-monthly reviews of patients with long-term conditions.

There was a prescription collection box at the reception desk and we observed that this was occasionally left unattended for short periods when the receptionist was not present at the desk. We also saw that some patients were handed their prescription without staff double checking their address and date of birth.

The practice participated in a prescribing incentive scheme as part of a local CCG network to reduce prescribing of antibiotics. We noted from the most recent audit that the practice had reduced its prescribing of antibiotics by 61% in the last three months.

Cleanliness and infection control

We observed the premises to be clean and tidy. There was a cleaning contract with an external company and the cleaning manager visited the practice monthly to review cleaning standards. Any issues would be raised with the practice manager. We noted the practice had been deep cleaned in July 2014 and we saw the record of this. We saw there were cleaning schedules in place in the toilets and reception area and cleaning records were kept of daily, weekly and monthly tasks completed. Patients we spoke with raised no concerns about the cleanliness of the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. The policy identified one of the GP partners as the clinical lead for infection control. There was also a policy for "needle stick" injury and posters on the prevention of injuries and first aid were displayed in the clinical rooms and at reception. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There were occupational health arrangements in place to ensure that all relevant staff were protected against Hepatitis B. We saw the immunisation status of some of the relevant staff was up to date. However, the practice was unable provide records of the status for the locum doctor and the practice nurse.

We saw evidence the practice had carried out an infection control audit in July 2014 using a detailed checklist and had not found any specific areas for improvement. The infection control policy stated that "infection control training will take place for all staff on an annual basis and will include hand washing procedures". All staff received induction training about infection control specific to their role and the recent infection control audit stated that training in hand hygiene had taken place within the last 12 months. Some staff had undertaken refresher training in infection control in May 2014, including the practice nurse and one of the partner GPs. However, the practice was unable to provide documentary evidence that up to date training had taken place in accordance with the infection control policy for three of the GPs, and a locum doctor.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in

Are services safe?

treatment rooms. Body fluid spillage kits and associated instructions were available in reception and in the nurse consulting room. All staff we spoke with knew where the kits were located and how to use them.

The landlords of the practice premises were responsible for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). They contracted a specialist company to carry out regular Legionella checks. We saw the record of the latest check which was done in August 2014.

Clinical waste was stored appropriately and a contract was in place for its collection and disposal.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence of calibration checks of relevant equipment that took place in January 2014; for example baby weighing scales, adult weighing machine, blood pressure monitors, spirometers, and the vaccine fridge. Nebulisers and thermometers were not included in this check but the practice manager undertook to ensure they were included in the next annual check in January 2015.

Staffing and recruitment

The practice had processes for the recruitment of staff and we saw copies of the application form, reference check letter and a person specification for the receptionist role as an example of these processes. However, the practice was unable to provide documented evidence of the interview and selection process and pre-employment checks for several members of staff. We were told checks undertaken before staff began work included checks for relevant qualifications and training, professional registration, identity, criminal records, permission to work in the UK, and references. We reviewed the recruitment records of the most recently appointed member of staff. We saw a CV and career history, checks of identity, professional registration and criminal records. However, there was no documentation relating to their interview and selection and no evidence of reference checks. At the time of the

inspection the practice was employing a locum doctor and agency nurse to staff a Saturday morning surgery. However, the practice was unable to provide evidence that it had sought information from the locum and nursing agencies to show that these staff were suitably qualified, skilled and experienced and all appropriate pre-employment checks had been carried out.

We were told that all staff also received a comprehensive induction as part of the recruitment process. We saw the form used for this purpose and staff we spoke with confirmed that they had followed an induction process and been provided with a clear job description which had been effective in helping them take on their new role.

We were told all staff had been subject to a criminal records check and many of these had been done when staff were employed by the former PCT. However, the practice only had a record of the check for three of the nine permanent staff and the locum and agency nurse. Updated checks had already been initiated for two staff before the inspection and checks for three more staff were applied for immediately after it. Confirmation regarding the check on the principle partner GP was still outstanding. However, the GP was on the NHS England National Performers list which provided assurance that a check had been made.

The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place to ensure there were enough staff on duty. There were also arrangements in place for members of staff, including doctors, nursing and administrative staff to cover each other's annual leave and during sickness. Nursing agency and locum staff were used as required. At the time of the inspection an agency nurse and a locum doctor were employed to cover the Saturday morning clinic.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular health and safety checks of the building, the environment, dealing with emergencies and equipment. The practice also had policies for health and safety, fire safety and practice security. Health and safety information was displayed for staff to see. We saw the reports of the most recent health and safety risk assessment carried out in the last year. We noted the action plan had been implemented.

Are services safe?

There was CCTV in operation within the building. The system was managed by an external company. However, there were no signs to indicate the system was in use and the practice was unable to show the system was registered with the Information Commissioners Office (ICO).

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. The practice used a risk stratification tool to identify patients over 75 at risk of hospital admission and put in place risk management plans as part of their care planning. There were emergency by pass numbers for these patients to use to enable timely telephone access to healthcare staff and care providers to discuss patients requiring a potential hospital admission. However, some patients we spoke with were not aware of this service. The practice opportunistically screened patients who may be at risk of dementia. The practice carried out monthly reviews of patients on long-term conditions registers for conditions including diabetes, epilepsy, depression, chronic kidney disease, obesity, learning disabilities, palliative care and osteoporosis to identify patients at risk of sudden deterioration in health. Risk calculations were made for patients aged over 30 with a strong risk of cardiovascular disease and incorporated into care planning.

The practice monitored repeat prescribing for people receiving medicines for mental health needs. The clinical team made use of a telephone psychiatry hot-line to access a consultant psychiatrist for advice. Patients were provided with an emergency psychiatric telephone number. The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND.

Arrangements to deal with emergencies and major incidents

The practice had emergency equipment available including a defibrillator, pulse oximeter and oxygen cylinder. Staff completed appropriate checks of oxygen levels and defibrillator and pulse oximeter operation and we saw during the inspection that the equipment was operational. Staff had received up to date training in dealing with medical emergencies.

We saw the report of the most recent fire safety risk assessment carried out in the last year. We noted the action plan had been implemented. There were weekly fire alarm tests and a designated evacuation assembly point if the building had to be vacated. There was a fire drill and evacuation plan and drills took place every 6 months. Staff received training in fire safety and there was a designated fire marshal.

The practice business continuity plan set out the arrangements to be followed in the event of major disruption to the practice's services. This plan covered communication; important contact numbers; telecommunications; roles and responsibilities of staff and managers; resources including continuity of computing and additional resources such as staffing, utilities, medication, and waste management; evacuation procedures and related security procedures; alternative accommodation arrangements through a local GP surgery the practice networked with; security; and provision of services for vulnerable patients.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw evidence of accurate and comprehensive patient assessments. Patients' medical history, examination and assessment were clearly recorded in their notes. The GPs and nursing staff kept up to date with relevant professional guidance through continuing professional development, NICE guidelines, patient safety alerts and other sources such as online clinical teaching sites. In addition, one of the partner GPs provided weekly undergraduate tuition to a medical student which required they kept up to date with current clinical practice. Clinical meetings took place weekly at which care planning and management of individual patients and groups of patients with specific conditions was reviewed. For example, we saw from recent minutes that the protocol for repeat prescribing for patients diagnosed with depression was discussed and a revised medication review process agreed.

Annual reviews were carried out on patients with long-term conditions in line with best practice guidance.

The practice participated in a local enhanced service scheme to deliver a shift in care from acute mental health services to community and primary care settings as part of the North West London-wide 'Shifting Settings of Care' strategy. Patients discharged from acute services were referred to the practice for ongoing primary care treatment. The practice was supported by a community mental health worker to manage mental health patients so that they received care closer to home and not in hospital where appropriate.

We saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

The practice routinely gathered information about people's care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess performance. The QOF is a national group of indicators, against which a practice scores points according to their level of achievement in the four domains of clinical, organisation, patient experience and additional services. QOF data for 2013/14 showed for the 20 clinical indicators the practice overall performed 5% below average compared with other practices in the local CCG area. In eight of the clinical indicators it performed

above the CCG average, in line with the average on one indicator and below average for nine indicators. In two other domains the practice performed broadly in line with the CCG and in patient experience the practice performed around 3% above the average. QOF data was reviewed at monthly QOF meetings to focus on areas for improvement. We saw, for example the minutes for the September 2014 meeting when the practice registers for patients with asthma, cancer, cardiovascular disease, dementia and depression were reviewed in relation to QOF data.

The practice had a system in place for undertaking clinical audit. For example, prior to the inspection the practice provided an example of an audit completed in March 2014 on hypertension in diabetic patients and the effectiveness of its treatment. The audit involved monitoring blood pressure of patients with more and less severe hypertension and using the information to reduce blood pressure by applying intensive anti-hypertensive therapy. The results showed that although there was a noticeable improvement in blood pressure for both categories there was still room for further intervention. The audit action plan required that all diabetics must have their blood pressure monitored regularly and the necessary anti-hypertensive therapy prescribed until good control was achieved. We did not however, see evidence of how the action from this or any audits of other clinical areas had been monitored and reviewed by further audit to test its effectiveness and complete the full clinical audit cycle.

Effective staffing

We saw evidence that the GPs kept their skills up to date through regular training and continuing professional development. We were told all the GPs in the practice undertook an appraisal as part of their GP revalidation. The practice manager had a record of the latest appraisals for two of the doctors but was unable to show us evidence for the other two and there was no overall practice co-ordination of the completion of the revalidation process.

There was an appraisal system for nursing and non-clinical staff which included a review of performance, objective setting and the identification of learning and development needs. We saw that staff records included evidence of completed appraisal reports. Staff confirmed they had received an appraisal and that this included discussion and agreement of learning and development needs. Staff did not receive formal supervision but said they could access a

Are services effective?

(for example, treatment is effective)

manager for advice whenever they needed to. Nursing and administrative staff attended a monthly whole practice meeting, chaired by the practice manager. All staff were invited to submit agenda items and minutes were distributed by email after each meeting.

The practice had a range of human resource policies which were accessible to all staff, along with clinical practice policies and procedures.

We looked at the records of eight individual staff which showed that they had received mandatory training and additional learning and development identified as part of the appraisal system. We were also shown the training matrix for each job role. Training completed included basic life support, child protection, fire safety and health and safety, infection control and safeguarding children. However, the practice was unable to provide documentary evidence of training undertaken for some staff, for example, in infection control and safeguarding children. We saw evidence of continuing professional development undertaken by clinical staff.

All the staff we spoke with said they felt equipped to do their job and were supported in their role.

Working with colleagues and 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 to meet patients' needs and manage complex cases.

Patients with complex needs at risk of admission to hospital were referred to a local CCG network based 'Virtual Ward' bringing together acute, community and social care professionals to work as one team. The Virtual Ward enabled this multi professional team of clinicians to care for patients in their own home. GPs from the practice attended fortnightly meetings with a health and social care co-ordinator for patients on the ward. The practice also referred patients to a multidisciplinary older people's rapid access (OPRAC) service for assessment and treatment. GPs from the practice attended monthly multidisciplinary meetings to review patients at risk of hospital admission. In addition the practice facilitated patients' access to the local '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.

There was an effective system in place for arranging and reporting the results of blood tests, x-rays and smear tests for example. This included a timely follow-up system to ensure these had been seen by the GP and actioned. Results were usually received electronically but urgent abnormal results (for example International Normalisation Ratio (INR) results for patients on anti-coagulants) would be faxed or phoned through to the practice. If test results were normal, reception staff provided the results to patients when they called in. For abnormal tests, the GPs reviewed the result and sent a letter out to the patient inviting them to attend for an appointment to discuss this. Two patients we spoke with were complimentary about the speed of the results service and the clarity of explanations about the results. One patient, however, felt the process took too long.

The practice had arrangements in place to manage lithium therapy, a treatment for mental health problems, including schizophrenia and bipolar disorder. This included regular blood testing and discussion with psychiatric consultants about any concerns identified. QOF data for 2013/14 showed that close to 74 % of these patients had a comprehensive care plan documented in the record, in the preceding 12 months, which was marginally below the CCG average.

The practice undertook child health surveillance through the 'Healthy Child Programme' which gives comprehensive advice on health and social care throughout childhood. There were quarterly meetings with health visitors to discuss patients on the practice's caseload. If any concerns were identified, referrals were made to a paediatrician. Health visitors were notified of all children under age 5 who registered at the practice.

The practice had out-of-hours (OOH) arrangements in place with an external provider, which comprised a team of GPs who provided the OOH primary care service on behalf of Hammersmith and Fulham CCG. Patients were advised that they could also call the 111 service for healthcare advice. The OOH service shared information about any care provided to practice patients electronically with the practice the next day. This was reviewed by the duty GP in case further action was needed.

We were told patients were offered choices about referrals for hospital appointments. The practice did not use the national 'Choose and Book' service as there had been new computer system problems which prevented use of the

Are services effective?

(for example, treatment is effective)

service. Referrals were made to mainly to two local NHS hospitals. One patient we spoke with told us they were always offered a choice of hospital. Two patients said they were not offered a choice when they had to go for an x-ray.

The practice had an effective process in place to follow up patients discharged from hospital. Discharge summaries were received electronically in most instances and were followed up by a GP within three days. The practice participated in a local enhanced service (LES) for unplanned admissions, reviewing discharged patients to determine if a hospital admission had been necessary. The practice nurse followed up the results of the review by inviting the patient to attend for a review and by completing with the patient a risk assessment of the patient returning to hospital.

The practice provided effective end of life palliative care. Appropriate records were kept for the patients currently on the register. Information was shared with the OOH service and the ambulance service through the 'Co-ordinate my Care' website. The practice worked closely with the local hospice for people receiving palliative care. There were quarterly multidisciplinary meetings to review patients on the practice's end of life care register, attended by a GP, the practice manager, a palliative care nurse, the community matron and a consultant. These meetings were minuted and we saw at the most recent meeting in September 2014 that the treatment of five patients was reviewed. At separate weekly clinical meetings the practice noted and discussed the death of patients on the register and after the meeting an email was sent to all staff to ensure the whole practice was informed.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local OOH provider to enable patient data to be shared in a secure and timely manner.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. This had been introduced into the practice during the year and staff were now fully trained on the system. Both clinical and administrative staff commented positively about the system's safety and ease of use, although they told us it was time consuming to use.

Consent to care and treatment

The practice had a comprehensive consent policy which set out why consent was crucial; what constituted consent; types of consent; obtaining consent; The Mental Capacity Act (2005); what information should be provided; recording consent; consent for children; obtaining written consent; and the patient consent procedure form. Staff understood the policy and confirmed they would always seek consent before giving any treatment. Patients we spoke with confirmed they were asked for consent before any treatment.

We found that staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. Children were always accompanied by a parent or guardian during treatment and consent was appropriately sought for them. The practice ensured vulnerable adults were accompanied by a carer or responsible adult. The staff demonstrated a clear understanding of Gillick competencies when asked about seeking consent. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

For significant procedures, staff recorded a patient's agreement to the procedure and the discussion leading to that agreement on a consent form which was scanned into the patient's notes. Any changes to a form, made after the form had been signed by the patient, were initialled and dated by both patient and the clinician.

Health promotion and prevention

There was a range of information available to patients in the waiting areas which included leaflets which could be taken away from the practice. Posters and displays promoted healthy living, for example on the smoking cessation campaign, 'Can you kick it?', and on sexual health and contraception.

The practice offered all patients in the 45-74 age group a health check. All newly registering patients were offered this check and it was provided opportunistically for other patients in this group when they attended for appointments. Two patients we spoke with in this group confirmed they had received health checks. Patients with a learning disability were offered a physical health check and all seven on the register had received one in the last 12 months.

Are services effective?

(for example, treatment is effective)

The practice proactively encouraged patients to manage their own care. For example, diabetic patients were given training to check their blood sugar levels. Doctors and nurses provided dietary advice and printed information for patients on healthy eating. Patients were referred to a dietician for additional support where appropriate.

The practice completed a cardiovascular disease (CVD) calculation for patients over age 30 with a strong family history of the disease. Health and lifestyle advice was provided to such patients to help reduce the risk of CVD.

The practice ran a regular women and men's health clinics and health and exercise advice was given at routine appointments. Winter and summer health advice was provided on the practice's website together with links to support services. There was also information about the NHS Choices 'Get fit for free' campaign. The practice offered a smoking cessation service and had a trained 'Stop Smoking Advisor' who held clinics at the practice every Wednesday morning. The number of smoking quitters in the last 12 months (April 2013 to March 2014) was 22 and the practice was 10th in the CCG area out of a total of 28 practices. The quit rate was 50 % and 35-70 % quit rates were considered standard.

The practice provided contraception and sexual health services including contraception advice and emergency contraception, smear testing and chlamydia screening. All patients, including street sex workers could register with the practice and a GP could refer them to a local genitourinary medicine (GUM) clinic for sexual health screening. The practice's performance for cervical smears was 69% in 2012/13 which was better than the average of 65% for the CCG area. However, the practice was seeking to achieve a higher rate as a priority.

The practice invited by letter all women between age 47 and 73 for breast screening every three years. All men and

women aged 60 to 69 were offered bowel screening every two years under a CCG led programme. Patients were sent a self-testing kit to do at home and post back for analysis. Results were returned within two weeks. New patients arriving from countries with high levels of tuberculosis (TB) were provided with information about TB screening when first registering with the practice. The practice opportunistically screened patients at risk of dementia and referred them to a memory clinic if appropriate. One patient we spoke with told us they received regular memory checks as they had got older.

The practice offered a full range of immunisations for children. According to NHS England data for 2013/14, the percentage receiving a vaccination at the practice was above the average within the CCG area for vaccinations in the 12 month age group, and below the average for the majority of vaccinations in the 24 months and five years age groups. Practice staff regularly produced a list of children due for immunisation and invited parents by letter to bring their child to the practice to have this carried out. The need for a vaccination would be raised opportunistically when children attended for general appointments, if there had been no response to the invitation letter.

Flu vaccination was offered to patients over the age of 65, those in at risk groups (including patients with long-term conditions) and pregnant women. The practice also offered shingles vaccinations to patients aged 70, 78 or 79, pneumococcal vaccinations to patients over age 65 and those at higher risk due to other illnesses and medical conditions, including patients with long-term conditions. Meningitis C vaccinations were offered to all new university students registering with the practice. Human Papilloma Virus (HPV) vaccination was offered to girls aged 12 to 18. The practice offered a full travel vaccination service.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 national GP patient survey, and a survey of 75 patients undertaken by the practice's Patient Participation Group (PPG) in 2013/14.

The evidence from these sources showed the majority of patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, in the PPG patient survey, 87% of respondents rated the GP as good or very good for care and concern and 90% the nurse. Data from the 2013/14 national GP patient survey showed the practice was rated above average in the CCG area for: levels of privacy, with a satisfaction score of 73%; for stating the last GP they saw or spoke to was good at treating them with care and concern, 84%; and for confidence and trust in the last GP they saw or spoke to, 94%. The practice was also rated above average in the CCG area for its satisfaction scores on consultations with doctors and nurses with 79% of practice respondents saying the nurse was good at listening to them and 85% saying the GP gave them enough time. However, 82% stated the GP was good at listening to them, which was below the CCG average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 44 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a pleasant service and staff were helpful, supportive and caring. They said staff treated them with dignity and respect, listened to them and met their needs.

We also spoke with seven patients and two representatives of the PPG on the day of our inspection. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us if they had any concerns or observed any instances where patients' privacy and dignity was not being respected they would raise these with their manager in the first instance. They were aware of the practice's whistleblowing policy which provided a formal process for raising such concerns.

During the inspection we were told of plans to form a joint reception with another GP practice that occupied part of the same building. This would be a return to arrangements that had been in place some months previously and was expected to be re-instated imminently. However, no risk assessment had been carried regarding issues of patient confidentiality and information security associated with these planned arrangements. With the proposed use of a shared printer and the possibility of open computer screens being visible to staff from the other practice's reception team there was the potential for patient confidentiality to be compromised. We observed during the inspection that there was no signage for patients to indicate that the building was occupied by two practices or where the other practice was located. We saw as a consequence confusion and annoyance in patients from the other practice who came to the Dr Das and Partners reception not realising their reception was on another floor.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice positively in these areas. For example, data from the 2013/14 national patient survey showed 78% of practice respondents said the GP was good at involving them in decisions about their care and 87% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area.

The majority of patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to ask questions and make an informed decision about the choice of treatment they wished to receive. However, one patient felt a lack of

Are services caring?

involvement and another felt the doctor did not always listen to what they were saying. Patient feedback on the comment cards we received was also mostly positive and aligned with these views.

Staff told us that translation services were available for patients whose first language was not English to help them with their communication needs. We saw notices in the reception areas informing patients this service was available. We noted that some information leaflets were provided in a different language. We saw also that the practice's website had a translation facility for each page in a wide choice of languages.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were positive about the emotional support provided, and this was reflected in the comment cards we received.

The practice provided appropriate support for end of life care. There were close links with the palliative care nursing team and staff at a local hospice who were involved in

regular multidisciplinary team meetings at the practice. GPs worked with the palliative care nurses to manage the care of patients receiving end of life care, including pain management and advice.

Although the practice was not Gold Standards Framework (GSF) accredited, a national standard of care for people nearing the end of life, the practice adopted and applied the principles of GSF, holding quarterly practice based multidisciplinary supportive care meetings. From this they identified appropriate patients considering current and future needs and patients' preferences, in accordance with the advance care planning principles. Summary care review forms were completed after every palliative care meeting and were added to the practice's clinical information system for all GPs to access. The review of patients on the palliative care register was also a standing item on the agenda for weekly clinical meetings.

Notices in the patient waiting room, also signposted patients to a number of end of life care support groups and organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The majority of patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and in most respects were happy with the service provided. This was confirmed in patient surveys conducted through the practice's patient participation group (PPG). Where necessary, the practice took action to address areas identified for improvement. The PPG was set up as part of a patient participation direct enhanced service (DES) to enable patients to provide feedback about the practice and contribute to improvements in service delivery. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from surveys conducted through the PPG. These included the introduction of an online booking system for appointments and for requesting repeat prescriptions, earlier surgery opening at 7.00am on Tuesdays, and the provision of additional services from the premises including a weekly smoking cessation clinic and physiotherapy services.

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. GPs and the practice nurse represented the practice at CCG meetings. As part of the CCG network arrangements the practice engaged regularly with other practices to review performance and discuss local needs and service improvements. A GP and the practice manager attended these meetings. We saw the minutes of the August 2014 quarterly network meeting and noted issues reviewed included practices' performance on referrals to the 'Improving Access to Psychological Therapies (IAPT)' programme, health checks for patients with learning disabilities, prescribing performance, and new gynaecological triage arrangements for referrals for secondary care to be commissioned by the CCG from January 2015. 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. For example, the practice was involved in an enhanced service scheme reviewing discharges to see whether hospital admissions could have been avoided.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments. For urgent appointments this was not always possible but patients we spoke with understood that they may have to see a different GP if they wanted an appointment on the day. The practice wrote to patients aged 75 or over notifying them of their named GP and aimed to ensure they saw the named GP at each appointment. Patients in this group were also invited to attend an appointment with the practice nurse to produce a care plan. One patient told us the reception staff always tried to ensure they saw their own doctor. In the national patient survey 2013/14 the practice scored above the CCG average for patients with a preferred GP who usually get to see or speak to that GP.

There were effective follow up procedures in place for vulnerable patients who did not attend appointments, for example, children on the 'at risk register' and patients with mental health problems. The GPs would contact the patients concerned or would ask other staff to do so to establish why they did not attend and encourage them to do so.

The practice had three male and one female GP and a female locum doctor and was able to offer some choice of male or female doctor if this was requested. However, the female doctors only carried out sessions on Monday, Tuesday and Saturday. One patient who had completed a CQC comment card stated that the lack of a regular female GP was a problem for them. Longer appointments were available for people who needed them and those with long term conditions.

The practice ran ante natal, post-natal and baby clinics.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients' and their families' care and support needs.

The practice provided clinics for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Annual reviews including a medication review were carried out on all patients with long-term conditions in line with best practice guidance. Regular checks were made on the practice's computer system,

Are services responsive to people's needs?

(for example, to feedback?)

which identified patients due a review. Patients with a mobile phone number were sent a text message inviting them to attend the surgery for a review. Patients with no mobile number or those who did not respond to texts were contacted by landline telephone. Checks were also carried out opportunistically when patients attended for other reasons for example blood tests.

For older patients and patients with long term conditions home visits were available where needed and longer appointments were provided when needed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients with complex needs who were at risk of admission to hospital were referred to a local CCG network based 'Virtual Ward'. The practice referred patients to a multidisciplinary older people's rapid access (OPRAC) service for assessment and treatment. Care plans had been introduced for people aged over 75. Annual health checks were provided for patients with learning disabilities.

The practice carried out six-eight week baby checks and provided a fast access service for babies to see a GP. Children under 10 years old would always be seen for an appointment if a parent felt there was a need for an urgent appointment. There was a dedicated baby changing room and mothers were able to breast feed in this room. The practice provided support to families experiencing domestic disputes and one member of staff had received training in this area.

The practice made regular use of a telephone psychiatry hot-line to a consultant for psychiatric advice. In addition the practice facilitated patients' access to the local 'Improving Access to Psychological Therapies (IAPT)' programme, including the 'Back on Track' programme which provided free workshops to help people manage stress and anxiety. The practice also referred people to MIND, a mental health charity for support and to a local NHS centre for mental health assessments.

The practice was accessible to vulnerable groups such as homeless patients and street sex workers. Such patients could register temporarily or permanently and the practice kept contact details where possible, including mobile phone numbers and relatives' contact information. They

also gave out information leaflets to enable these patients to contact the practice and kept details of any address where any correspondence may be sent. There was one homeless patient currently registered.

If patients requested an urgent appointment and GPs were fully booked, the GPs may speak to the patient to decide whether to re-prioritise the appointment list to enable them to be accommodated. They would refer to the patient's record as part of this process as the clinical system identified whether a patient was in a vulnerable group, for example children, patients with learning disabilities and patients on palliative care.

The practice had access to interpreter and translation services and the website had a translation facility in a wide range of languages. In addition, some information leaflets were provided in a different language, for example, regarding NHS Health checks and sexual health. The practice took account of patients' cultural and religious needs. For example, members of the Jehovah's Witness denomination were asked about their wishes regarding blood tests and an appropriate reference recorded on their medical record.

Nursing staff used sign language and drawings in communicating with patients with learning disabilities about their treatment. They would also involve their parent or carer if communication was difficult. In carrying out procedures such as smear tests, the nurse would explain the procedure, show the patient the equipment. They would then carry out the procedure, explaining what they were doing throughout the procedure, ensuring that that it was not rushed and the patient was comfortable as it proceeded.

The premises and services had been adapted to meet the needs of people with disabilities, including level access for wheelchair users and toilets for patients with a disability. Within the waiting area there was ample space for manoeuvring and suitable locations for wheelchair users. One patient we spoke with told us they found the practice very accessible in this respect. Chairs in the waiting area were clean, had armrests and were high enough for patients who lacked mobility, for example those with musculoskeletal disorders. The practice had an equal opportunities policy. Staff read the policy as part of the induction process but had not received specific equality and diversity training.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 09:30-12:00 and 16:30-19:00 Monday, Tuesday and Thursday and 10:00-12:00 and 16:30-19:00 Wednesday and Friday. Appointments were also available between 08:00-10:00 on Saturdays. Six urgent same day appointments were available to be given to patients each a day. Pre-bookable appointments were available up to four weeks in advance in person by phone or online. Telephone appointments were provided for patients who were unable to book a same day appointment and requests for this were triaged by the duty doctor. Patients were advised that nurses based in the practice provided treatment for a wide range of common conditions. Patients could expect to see a nurse within two working days and could book up to a month ahead for nurse-led clinics.

The practice worked closely with the community health care team, such as the district nursing team, midwives and health visitors. Patients could contact them either through reception or directly. If patients had an illness or incapacity that meant they needed nursing care at home, the district nurse would visit them. Patients who were likely to benefit from this service included the housebound, the elderly, patients with a terminal illness, and those who had recently been discharged from hospital.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Data from the 2013/14 national patient survey showed 81% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, which was below the CCG average. 90% said the last appointment they got was convenient which was above the average for the CCG area. The views from patients we spoke with and who completed comment cards were mostly positive about access to the service. However, there were some negative comments about the difficulty in getting an appointment and getting through to the surgery on the telephone during

busy times. The data from the latest patient survey conducted by the practice's patient participation group (PPG) showed 89% of respondents found it easy or fairly easy to get through to the practice but only 47% said they are normally seen by any GP the same day or next day. 84% considered waiting times good, very good or excellent. The national patient survey also showed waiting times as an area where the practice was rated highly with 87% of respondents saying they usually wait 15 minutes or less after their appointment time to be seen.

The updated action plan in response to the 2013/14 PPG survey noted that patients showed less satisfaction regarding seeing any GP on the same day or next day and that patients were now more dissatisfied regarding it not being easy to speak to a doctor or nurse on the phone. The updated action plan included agreement to carry out an additional review of these two areas. A more positive response was noted regarding seeing a GP urgently on the same day, wanting to wait less than 5 minutes to see their GP on the day of their appointment, and wanting the GP/ Nurse to help to understand their problems. Action taken by the practice to achieve improvements included, the addition of four new emergency slots within each GP session which could be booked only on the day of the session; GPs monitoring consultation times and the introduction of built in additional 'catch-up' slots for GPs.

The Surgery – Dr Das and Partners was located in a building shared with another GP practice. The practice reception, waiting area and consultation rooms were situated on the ground floor of the building. The other practice was located on a different floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was a notice

Are services responsive to people's needs? (for example, to feedback?)

about complaints in the waiting area which gave information about how to complain, what the practice did with complaints and the help patients could get elsewhere including the Health Service Ombudsman and the NHS Complaints Advocacy service. There was also a suggestion box in the waiting room where patients could make suggestions or comments, although we were told this was not in use at the time of the inspection. If patients wished to complain they were advised to request a complaints form at reception. They could also complete an online form to inform the practice of a complaint, compliment or comment through the practice website. Only one of the patients we spoke with had needed to make a complaint about the practice. They did not feel that the practice had addressed their concerns.

Before the inspection we asked the practice to submit information on written complaints received in the last twelve months. They told us they held an annual meeting

to review all complaints to identify themes or trends. They submitted the report of the May 2014 complaints review meeting, which recorded that there had been no written complaints between April 2013 and March 2014. At the inspection we were shown the annual review of complaints for 2012/13. We saw that learning points were identified but we did not see documented evidence to confirm that this information had been communicated throughout the practice. However, one member of staff told us if the outcome of a complaint was relevant to their work area, the practice manager would provide informal feedback. We reviewed a recent written complaint and saw the response from one of the GP partners included an apology in relation to a number of issues, explanations to address some misunderstanding, a commitment to discuss the complaint with colleagues to avoid a recurrence of similar problems in future and an offer to discuss the matter further if the complainant wished to do so.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear ethos which involved putting 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's statement of purpose set out the aim to: provide patients with personal health care, of high quality and to seek continuous improvement to their health status; and provide a service responsive to people's needs and expectations and which reflected whenever possible the latest advances in primary health care. Not all staff were aware of this statement and it was not on display for patients. However, all staff were able to articulate the essence of the stated aims and it was clear that patients were at the heart of the service they provided. The practice prided itself on providing a family orientated service and patient feedback largely reflected this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the computer system within the practice and in hard copy. There was a staff handbook containing appropriate human resource policies. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff. There was no formal review schedule for the practice's policies and procedures. They were, however, updated on an ad hoc basis to take account of new developments and changes in guidance or legislation.

The practice held clinical governance meetings on Tuesday and Thursday each week, although only the Thursday meetings were minuted. We saw from looking at a sample of minutes in the last nine months that performance, quality and risks had been discussed and there was on going review of individual patients and groups of patients with specific conditions.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that QOF data was regularly discussed at monthly QOF meetings and follow up action agreed to maintain or improve outcomes. The deputy practice manager also met individual GPs fortnightly to review data between the formal meetings. QOF data for 2013/14 showed for the clinical indicators the

practice performed 5% below average compared with other practices in the local CCG area. In two domains, organisation and additional services the practice performed broadly in line with the CCG and in patient experience the practice performed just over 3% above the average.

As part of the CCG's network arrangements, the practice took part in local peer review with neighbouring GP practices to measure their service against others and identify areas for improvement. We saw the minutes of the August 2014 network meeting and noted that performance reviews included IAPT referrals, health checks on patients with learning disabilities, and prescribing.

The practice had undertaken a number of clinical audits and we saw evidence of these including audits of patients with osteoporosis (a skeletal disorder) at risk of fracture; an audit of patients referred to hospital for ophthalmology (the medical and surgical management of conditions of the eye); and an audit of hypertension in diabetic patients and the effectiveness of its treatment.

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. The practice manager told us the plan had been reviewed in October 2014 and no changes made since the last review in 2010. We saw this was reflected in the latest document. There were regular health and safety and fire risk assessments of the practice environment and equipment. We saw the action plan for the February 2014 health and safety audit and observed that all the action had been implemented. The practice regularly monitored and reviewed risks to individual patients and updated care plans accordingly.

Leadership, openness and transparency

The practice had a clear management structure with designated leads for clinical and administrative areas. For example, the practice nurse was the lead for infection control and there were GP leads for paediatrics and child protection and prescribing. All staff had job descriptions and clearly defined roles which they knew and understood and which were subject to annual review. There were HR policies and procedures to support staff.

In addition to regular clinical meetings there were approximately six-weekly whole practice meetings involving clinical and administrative staff. All staff were

Are services well-led?

Good 

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

invited to submit agenda items for discussion. Staff told us the practice partners fostered an open and learning culture and staff commented positively on the support they received. We heard that praise from patients was celebrated and fed back to all staff. For example, the Adult Learning Disability Service complimented practice staff about the management of a patient's first visit to the practice and the care, sensitivity and patience shown to the patient. Staff concerned received an email praising their contribution.

The practice manager was responsible for human resource policies and procedures including equal opportunities, sick absence, whistleblowing grievance and discipline. We reviewed a number of policies, for example recruitment, induction and staff appraisal which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, the NHS Choices website and complaints received. We looked at the results of the annual patient survey and saw the practice had developed action plans as a result of the feedback received. For example, patients had asked for the surgery to open at 7am on Tuesdays instead of 8am and the practice had put this in place.

The practice participation group (PPG) met quarterly and there were four female and two male representatives. The PPG's annual reports, including the results and actions agreed from patient surveys, were available on the practice website. The group's action plans were discussed and agreed by the practice partners. We spoke with two members of the PPG on the day of the inspection who supported the idea of having a PPG.

The practice gathered feedback from staff through staff meetings, appraisals and day to day informal discussions. Staff told us their managers were very approachable and they felt free to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, we heard that extended opening hours had been openly discussed and staff were able to contribute their views. In addition they felt fully informed about changes in the practice partnership. However, we found communication was not as good as it could be on some issues. For example, in the practice's patient survey only 71% of patients said their GP or nurse helped to understand their problems very well. This information had not been fed back to or discussed with the practice nurse.

The practice had a whistle blowing policy which was available to all staff in the staff handbook. All staff we spoke with were aware of the policy and the process to follow if they had any concerns.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and saw that regular appraisals took place which included a learning and development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents which included lessons learned. We were told that any significant events would be discussed at practice meetings. However, such events were not a permanent item on the agenda of these meetings and we did not see documented evidence of the dissemination of findings and follow up action within the practice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because records about staff employed to carry out the regulated activities were not always accurately maintained. (Regulation 20(1)(b)).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider must ensure patients are fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post. (Regulation 21 (a) and (b)).