Pauline Lai Chung Fong

Quality Report

Queens Park Surgery
Queens Park Health Centre
Dart Street
London
W 10 4LD
Tel: 020 8969 1490
Website: None

Date of inspection visit: 14 May 2014
Date of publication: 20/08/2014

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.

Summary of findings

Contents

Summary of findings

Overall summary

Dr Pauline Lai Chung Fong is an individual GP practice located in Queens Park Health Centre, in the London borough of Westminster. The health centre comprises of two other surgeries and community services patients can access. The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, and treatment of disease, disorder or injury.

During our inspection, we spoke with patients who used the service, carers, a member of the Patient Participation Group (PPG) and staff. All the people we spoke with were very complimentary about the treatment and care they had received, and they felt it was a very well managed service.

We found patients were protected from the risk of abuse because the provider had procedures in place for safeguarding vulnerable adults and children, and the staff we spoke with were aware of these procedures. The provider had effective systems in place for the safe management of medicines, equipment, infection control and dealing with emergencies. Patients using the service were treated with dignity and respect, and they felt involved in decisions about their care and treatment.

The practice worked with other providers to ensure patients were supported to maintain good health; and people's care was planned and delivered to meet their individual needs. The provider recruited staff with suitable qualifications, skills and experience to meet the needs of patients using the service. The staff we spoke with told us an open and learning culture was promoted within the service; and this included learning from incidents, complaints and clinical audits to help improve the service.

The practice provides services to about 1,800 patients within the local area. We found specific care pathways and risk registers were regularly reviewed for most of the six population groups that we inspected. This included case management with other multi-disciplinary professionals in both primary and secondary care for older people, people with long term conditions, mental health needs, mothers and children, and people in vulnerable circumstances.

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 had arrangements in place to ensure a safe service was provided.

Patients we spoke with told us they felt safe when accessing the service and expressed no concerns about the service provision. The practice had systems in place to promote learning from incidents, to monitor risk and ensure safe patient care. Staff had received local guidance and training about safeguarding children and vulnerable adults against the risk of abuse.

Appropriate arrangements for the management of medicines were in place. This included the recording, handling, safe keeping, administration and disposal of medicines.

The practice had a business continuity plan which detailed the arrangements for dealing with foreseeable emergencies. Staff we spoke with demonstrated awareness of how to respond in a medical emergency and regular checks of resuscitation equipment and drugs were undertaken to ensure they were fit for purpose.

Electrical and clinical equipment were periodically serviced to ensure the safety of patients. Appropriate standards of cleanliness and hygiene were maintained to reduce the risk and spread of health acquired infections.

Are services effective?

The practice had arrangements in place to ensure an effective service was provided.

Care and treatment was delivered in line with guidance published by professional bodies. The practice participated in clinical audits and external peer group meetings, and this contributed to improvements in specific areas of clinical care.

Appropriate and timely referrals were made to community and hospital services for diabetes management, dermatology and rapid response nursing to improve the treatment and care of patients using the service.

Patients were given appropriate information and support regarding health promotion and prevention. Patients' needs were met by suitably qualified and experienced staff; and plans were in place to recruit a permanent practice nurse to ensure consistency in care.

Summary of findings

Are services caring?

The practice had arrangements in place to ensure a caring service was provided.

Patients we spoke with told us they were treated with dignity and respect, and felt well informed and involved in decisions about their care. Information regarding the available services including local resources for counselling, carers and specific medical diagnosis were provided in the practice leaflet and / or displayed in the reception area for patients to access.

We found people's care was planned and delivered in a way that met their individual needs; and the practice worked in liaison with other healthcare professionals and services. The staff we spoke with demonstrated an understanding of consent and capacity issues, including supporting patients to make choices and decisions for themselves.

Are services responsive to people's needs?

The practice had arrangements in place to ensure a responsive service was provided.

Patients we spoke with told us they could contact the practice easily to make a suitable appointment. A triage system was in place for patient's needing home visits, urgent appointments, and telephone consultations.

Suitable arrangements were in place to identify people's individual preferences, ethnic and cultural needs in order to inform the planning and delivery of their medical needs. Arrangements were in place to enable patients with diverse needs to access the service.

The practice had a Patient Participation Group (PPG) and used patient feedback including complaints to improve the service. Buddying arrangements were also in place with other GP surgeries within the health centre to ensure patients could access a range of community services to meet their needs.

Are services well-led?

The practice had arrangements in place to ensure a well-led service was provided.

There was an established management structure in place with clear delegation of tasks and responsibilities for both clinical and non-clinical staff. Staff we spoke with felt valued and supported by management in relation to their roles and training.

Summary of findings

Governance arrangements including risk and performance management enabled the provider to monitor and improve co-ordinated care pathways for people using the service. The practice had effective systems in place to identify and manage risks, and improve the service.

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 had arrangements in place to meet the needs of older people.

Patients we spoke with told us staff were caring, responsive to their medical needs and treated them with respect. We found older people with long term conditions had their care coordinated by the GP practice together with professionals such as the district nursing and palliative care teams. Written information relating to age-related conditions such as Dementia and support groups was available for older people to access.

People with long-term conditions
The practice had arrangements in place to meet the needs of people with long health conditions.

The practice worked in collaboration with providers of community health care services and secondary care to ensure that coordinated and multi-disciplinary care planning and review took place. Clinical audits were used to reflect on the appropriateness of referrals and / or treatment provided to patients using the service. People with long- term conditions were signposted to services such as counselling and support groups for carers to ensure their emotional needs were met.

Mothers, babies, children and young people
The GP practice provided services such as baby immunisations and six weekly health checks; and patients in this population group could access community services such as baby clinics and family planning services within the health centre.

The GP practice provided a safe, caring, responsive and well led service in collaboration with the hospital paediatric team, health visiting team, local authority and other GP practices within Queens Park Health Centre.

The working-age population and those recently retired
The practice had arrangements in place to meet the needs of this population group.

We found people were treated with dignity and respect when visiting the practice and they were involved in making decisions about their treatment. Patients told us they had no problems arranging appointments which suited them and suitable arrangements were

Summary of findings

in place to obtain emergency appointments. Patients had access to the practice information leaflet and notice board which detailed the different services available to them. Clinical audits were used to risk assess and manage health outcomes for patients using the service.

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

The practice had arrangements in place to meet the needs of people in vulnerable circumstances.

The practice supported patients to access primary care by maintaining them on their practice list and where appropriate, reviewed their care even though they were homeless or moved outside of the area. Patients in this population group were supported to access health promotion advice and external services from voluntary and statutory organisations in relation to their social care needs.

People experiencing poor mental health

The practice had arrangements in place to meet the needs of this population group.

The practice provided a safe, effective and caring service for people experiencing mental health problems. This included liaison with mental health professionals and referrals to community services to prevent people from experiencing a mental health relapse.

Summary of findings

What people who use the service say

The results from a patient survey undertaken by an independent service in June 2013 showed that most respondents agreed strongly to all questions asked in relation to positive staff attitudes, involvement in the planning and delivery of care, and maintaining patient confidentiality. In addition, all 44 respondents felt confident in the doctor's ability to provide care and were completely happy to see the doctor again. Patient comments in the survey included: "great to have a GP who knows you as a person", "I am satisfied by the doctor's service" and I was "told a possible long waiting time but seen within 10 minutes of arriving. Brilliant".

Areas for improvement

Action the service COULD take to improve

- Establishing and improving patient online access to GP services.
- Organisation of staff recruitment and training records in a way that would enable information to be easily accessed.

Good practice

Our inspection team highlighted the following areas of good practice:

- Use of clinical audits and external peer review feedback to risk assess and monitor the quality of service provision.
- Multi-disciplinary working with other healthcare professionals and services to ensure co-ordinated pathways of care to meet patients' health and social care needs.
- The GP visited patients that had been discharged from hospital and developed appropriate care plans to avoid further admission.
- Older people were referred to the rapid response service for community support if they were identified as being at risk of a hospital admission.

Pauline Lai Chung Fong

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The lead CQC inspector was accompanied by a GP and an Expert by Experience. They were all granted the same authority to enter The Pauline Lai Chung Fong's (Queens Park) Surgery as the CQC inspector.

Background to Pauline Lai Chung Fong

Dr Pauline Lai Chung Fong is an individual GP practice located in Queens Park Health Centre in the London borough of Westminster. The health centre comprises of two other surgeries and community services people can access. The practice has a patient list size of about 1 800, and an approximate ethnic breakdown of one third White, Asian and Black African/Caribbean population groups.

Most of the patients accessing the service fall within the working age population (19 to 74 years) and / or have long term conditions. The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures, and treatment of disease, disorder or injury.

Westminster is a central London area within the City of Westminster. The 2010 Indices of Deprivation showed that the City of Westminster was the 75th most deprived local authority (out of 326 local authorities, with 1st being the most deprived). In Westminster, 33.2% of the population belong to non-white minorities (England average 12.3%). Arabian people constitute the largest ethnic group (7.2%), with other Asian people accounting for 4.6% of the population, and African people 4.2%.

The Office for National Statistics and Public Health Observatory records showed the health statistics for smoking in pregnancy, obesity in adults, and the incidence of malignant melanoma in Westminster is significantly better than the England average. Significantly worse than the England average are health indicators for obesity in children, sexually transmitted infections, and drug misuse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 14 May 2014. During our visit we spoke with a range of staff (GP, Practice Manager, Health Care Assistant, Reception staff and the cleaner) and spoke with patients who used the service. We reviewed information given to us by the provider, NHS England, West London Clinical Commissioning Group (CCG) and the local Healthwatch.

Are services safe?

Summary of findings

The practice had arrangements in place to ensure a safe service was provided.

Patients we spoke with told us they felt safe when accessing the service and expressed no concerns about the service provision. The practice had systems in place to promote learning from incidents, to monitor risk and ensure safe patient care. Staff had received local guidance and training about safeguarding children and vulnerable adults against the risk of abuse.

Appropriate arrangements for the management of medicines were in place. This included the recording, handling, safe keeping, administration and disposal of medicines.

The practice had a business continuity plan which detailed the arrangements for dealing with foreseeable emergencies. Staff we spoke with demonstrated awareness of how to respond in a medical emergency and regular checks of resuscitation equipment and drugs were undertaken to ensure they were fit for purpose.

Electrical and clinical equipment were periodically serviced to ensure the safety of patients. Appropriate standards of cleanliness and hygiene were maintained to reduce the risk and spread of health acquired infections.

Our findings

Safe Patient Care

Patients we spoke with felt safe when supported by staff and reported no concerns about the safety of the service. The practice had effective processes in place to ensure all staff had a shared awareness of the procedures to report and record safety incidents, complaints and allegations of abuse. Records reviewed showed the practice addressed identified concerns and risks in a timely way to ensure patients received safe care.

Learning from Incidents

The practice had suitable systems in place for investigating incidents and reviewing the outcomes. Records showed the investigation of incidents included: undertaking a root cause analysis, grading the risk of the incident and identifying improvement strategies to minimise the likelihood of the incident happening. Practice meeting minutes showed learning from incidents was shared with staff and action was taken to improve the service.

Safeguarding

The practice had safeguarding procedures in place to guide staff about their role in preventing abuse from happening and to promote the welfare of children and vulnerable adults. Staff we spoke with demonstrated awareness of these procedures and the potential signs of abuse they would look out for when dealing with vulnerable patients. Flow charts summarising the process for raising concerns and contact details for the local safeguarding teams were clearly displayed, and available to staff for guidance.

Training records showed all staff had attended safeguarding children training at an appropriate level within the last ten months; for example non-clinical staff had completed level one training and clinician's level three. Practice meeting minutes we looked at also showed that safeguarding was a regular topic for discussion to ensure staff maintained their knowledge.

The practice had completed a safeguarding children audit in February 2014 as required by the local Clinical Commissioning Group. The audit showed the practice was completing their statutory duties with regards to Safeguarding as laid out in Working Together 2013 guidance.

The practice had a whistleblowing policy in place and most staff we spoke with were aware of the procedure to follow

should they need to raise concerns about a colleague and / or poor practice within the service. However, the practice policy did not include the external agencies staff could also contact; for example the General Medical Council, NHS England and the Care Quality Commission. This was discussed with the provider on the day of our inspection and the GP told us they would update their policy.

Monitoring Safety & Responding to Risk

The practice reviewed identified risks to patients' treatment and care. This included responding to medical alerts and information received from external bodies.

Medicines Management

The practice had medicine management policies in place to ensure staff had guidance related to medicines handling, and in-house training was provided for staff. We saw examples of the policies and procedures related to repeat prescribing and controlled drugs. Staff we spoke with were aware of their responsibilities in relation to the management of medicines and prescriptions. Patients we spoke with told us their prescriptions were processed within 48 hours and this ensured they had their medicines at the times they needed them.

The GP's prescribing practice was regularly monitored through clinical audits, improvement plans and assessment by the North West London Commissioning Support Unit as part of the Prescribing Standardisation Scheme. As part of this scheme, the practice was required to submit an action plan to the Medicines Management Team identifying the five prescribing areas for improvement.

For example, the practice's 2013/14 prescribing improvement plan included reviewing the records of all people taking warfarin to ensure they were attending a warfarin management service. The plan included the need for appropriate dose adjustments where required, and that blood results were recorded on the clinical system 12 weeks before the last prescription was made.

All the patients we spoke with told us their medicines were reviewed on a regular basis and adjusted as their condition changed. This ensured people's prescribed medicines were regularly monitored to meet their assessed needs.

Records we looked at showed that fridge temperatures were checked every day when the surgery was open to ensure medicines such as vaccinations were in date and stored at an appropriate temperature in line with the manufacturers' guidelines.

Cleanliness & Infection Control

We observed that the practice was visibly clean and an external company managed the cleaning services and maintenance of the premise. Appropriate facilities for hand-washing, anti-bacterial gel were available including personal protective equipment such as disposable gloves. There were arrangements in place for the disposal of clinical waste. Staff told us they had received infection control training and certificates we looked at confirmed this. The provider had a process in place for monitoring and sampling water for Legionella to protect people from the risk of infection.

Staffing & Recruitment

The practice had recruitment and selection procedures in place to ensure patients were cared for and supported by suitably qualified, skilled and experienced staff. This included assessing an applicant's suitability through an interview process, pre-employment checks, completing a probationary period and ongoing professional development.

Appropriate pre-employment checks were completed for most staff before they began work. These checks included proof of identity, legal entitlement to work in the UK, references, professional registration and criminal record checks for clinical staff. Risk assessments were completed retrospectively where criminal record checks had not been undertaken for some non-clinical staff.

Dealing with Emergencies

The practice had procedures in place for checking emergency equipment and drugs to ensure they were available and accessible for use in a medical emergency. For example, records showed the doctor regularly checked the defibrillator was in working condition and that adequate medication stocks were maintained including an anaphylaxis kit. Emergency drugs were in date and stored securely.

Training records showed all staff had received yearly training in performing basic life support, cardio-pulmonary resuscitation (CPR), recognising and managing

anaphylaxis. We noted the training delivered had been informed by the Resuscitation Council (UK) guidelines to ensure staff competence was assessed in line with best practice.

Equipment

Annual portable appliance testing had been conducted on electrical equipment such as fridges; and clinical equipment such as blood pressure monitors and weighing scales had been serviced and calibrated to ensure they remained suitable for use.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice had arrangements in place to ensure an effective service was provided.

Care and treatment was delivered in line with guidance published by professional bodies. The practice participated in clinical audits and external peer group meetings, and this contributed to improvements in specific areas of clinical care.

Appropriate and timely referrals were made to community and hospital services for diabetes management, dermatology and rapid response nursing to improve the treatment and care of patients using the service.

Patients were given appropriate information and support regarding health promotion and prevention. Patients' needs were met by suitably qualified and experienced staff; and plans were in place to recruit a permanent practice nurse to ensure consistency in care.

Our findings

Promoting best practice

Clinical audits and information submitted to external bodies such as NHS England and the Clinical Commissioning Group showed the practice took into account guidance published by professional and expert bodies. This included quality standards issued by the National Institute for Health and Care Excellence (NICE) to inform the delivery of safe patient care.

The GP participated in external peer review meetings and periodic multi-disciplinary meetings to discuss current and best practice guidelines for the treatment and care of patients. This helped to drive continuous improvement in achieving good health outcomes for patients.

Management, monitoring and improving outcomes for people

The GP undertook regular clinical audits to help improve the quality of services provided and to check that appropriate care and treatment had been delivered in line with evidence based practice. For example, following new guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) to reduce the dosage of simvastatin from 40mg to 20mg due to side effects, a clinical audit was completed. This audit identified affected patients of whom all received a review of their health needs and changes were made to their prescribed medicines.

Meeting minutes showed the GP practice participated in external peer group meetings where specific outcomes such as reducing inappropriate outpatient referrals and avoidable hospital attendances were discussed. The November 2013 results made available to the practice by the CCG showed a 9% reduction in accident and emergency admissions for the practice following the implementation of an improvement plan in June 2013.

Staffing

The staffing structure comprised of the GP, two part-time practice managers, a locum practice nurse, a health care assistant and three reception staff. The provider told us there was sufficient staff to meet the needs of patients and plans were in place to recruit a full-time nurse as this role was being covered by a locum nurse three days a week. Staff told us they felt well supported by management and could access additional training and one to one supervision meetings when required.

Are services effective?

(for example, treatment is effective)

Records we looked at showed staff had received mandatory training related to their specific roles and a yearly appraisal which considered their performance during the year, improvement areas and agreed learning needs. We found most of the staff had been employed before the provider was registered with the Care Quality Commission and records of the induction completed were not readily available; although staff told us they had received it and were clear about their roles and responsibilities as detailed in their contract of employment. This was discussed with the practice manager and they told us they were in the process of formalising their induction checklist for different roles.

Working with other services

The GP practice worked in partnership with a range of external professionals in both primary and secondary care to ensure integrated care pathways for patients using the service. For example, records we looked at showed regular multi-disciplinary meetings were held with the palliative care team, health visitors and the community matron. Information discussed included: care planning for people with multiple and long term conditions to minimise frequent hospital admissions, monitoring and provision of appropriate health and social care support for families where concerns related to a child's development and / or domestic violence were noted. The GP practice also referred patients to hospital for services such as dermatology, minor injuries and orthopaedic, where required.

Health, promotion and prevention

All new patients were required to complete a patient registration form which included sections on medical history and social factors such as smoking, alcohol consumption and exercise. This information together with a physical examination / health check formed basis for assessing a person's needs in relation to health promotion and the clinician providing advice.

The reception area had a range of health promotion information for patients to access and read. This included smoking cessation and cervical screening services which were provided at the practice.

Patients could access other services such as family planning within the health centre. Patients who required on-going support with their health conditions such as chronic obstructive pulmonary disease (COPD), heart disease, asthma and childhood immunisations were subject to recall time periods to ensure they were followed up in a timely period.

Are services caring?

Summary of findings

The practice had arrangements in place to ensure a caring service was provided.

Patients we spoke with told us they were treated with dignity and respect, and felt well informed and involved in decisions about their care. Information regarding the available services including local resources for counselling, carers and specific medical diagnosis were provided in the practice leaflet and / or displayed in the reception area for patients to access.

We found people's care was planned and delivered in a way that met their individual needs and the practice worked in liaison with other healthcare professionals and services. The staff we spoke with demonstrated an understanding of consent and capacity issues, including supporting patients to make choices and decisions for themselves.

Our findings

Respect, dignity, compassion and empathy

Patients using the service told us they were happy with the arrangements for ensuring their privacy and dignity was maintained. For example, consultations with the GP and / or nurse were undertaken in a private and lockable room, and where a physical examination needed to be carried out curtains were used in the consultation room. There were notices in the reception area and doctor's consultation room highlighting the availability of a chaperone service if a patient required this.

We observed staff taking care to protect patient's privacy when discussing information at the reception desk. However, the reception area was shared with two other GP practices and if patients needed to discuss confidential information it was an open space with limited room for privacy. The practice manager told us that patients could discuss their personal information with staff in a private room if required. Training records we looked at showed all staff had received training on information governance including secure handling of confidential information.

All the patients we spoke with told us their doctor was very caring, compassionate and offered re-assurance where appropriate. People described reception staff as being polite, respectful and very helpful; and this is what we observed on the day of our inspection. Our findings were also reflected in an independent survey undertaken by an external organisation on 19 June 2013. This survey showed 98% of the 44 respondents felt staff were polite and listened to them. We noted that the patient feedback results had been benchmarked against results collected nationally and the scores achieved were all above the national average.

Involvement in decisions and consent

Patients' we spoke with told us clinical staff discussed their medical conditions and treatment in a way they could understand and they felt listened to, and were able to ask questions. One respondent to the June 2013 survey commented the doctor "never rushes you, when you see her she puts you at ease and gives you plenty of time and explains things very clearly in a way patients understand".

The GP and practice manager confirmed the service was able to offer appointments of appropriate durations to ensure patients' had enough time to discuss their health

Are services caring?

needs or treatment in full. One patient we spoke with confirmed they had been given options as to where they could be referred to for further treatment and we saw examples where patient requests to be referred to a specific hospital and / or consultant had been arranged by the GP.

Patients using the service were given appropriate information and support regarding their care and treatment. The provider had a practice leaflet in place and this outlined the available services, how to make an appointment and get the results of hospital tests for example. The GP told us they signposted patients to local organisations where a need was identified and with their consent. For example, counselling support in relation to bereavement, support groups and activities for carers, specific diagnosis and sexuality such as HIV positive men and Alzheimer's. We were shown a variety of information leaflets provided and these were also displayed in the reception area for patients to access.

The GP told us that before patients received any care or treatment they were asked for their informed consent and they acted in accordance with their wishes. Where people did not have the capacity to consent the provider had procedures in place to assess people's capacity for specific healthcare decisions in line with the Mental Capacity Act (2005) / and or seek parental consent for children.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had arrangements in place to ensure a responsive service was provided.

Patients we spoke with told us they could contact the practice easily to make a suitable appointment. A triage system was in place for patient's needing home visits, urgent appointments, and telephone consultations.

Suitable arrangements were in place to identify people's individual preferences, ethnic and cultural needs in order to inform the planning and delivery of their medical needs. Arrangements were in place to enable patients with diverse needs to access the service.

The practice had a Patient Participation Group (PPG) and used patient feedback including complaints to improve the service. Buddying arrangements were also in place with other GP surgeries within the health centre to ensure patients could access a range of community services to meet their needs.

Our findings

Responding to and meeting people's needs

Patients we spoke with told us they were able to arrange appointments which suited them and had the option of ringing on the day or making an advance booking. Minutes of practice meetings showed discussion between the GP and staff regarding the importance of triaging patient's medical needs and seeking clinical advice when a patient needed to be seen or speak to a GP in an emergency. Staff we spoke with told us additional slots and / or telephone consultations could be added to the doctor's schedule if a patient needed to be seen urgently. Home visits were also arranged for patients who could not visit the surgery in person to ensure they received care responsive to their needs.

Access to the service

People's diversity, values and human rights were respected. All new patients' were required to include information such as their primary language of communication, specific needs related to any disabilities and requirements needed to access the practice premise at the point of registration. Staff told us this information was then used to identify any adjustments required for individual patients. For example, interpretation services were available to people for whom English was not their first language, the premises was wheelchair accessible and hearing loops were in place to support communication with people with sensory impairments.

Concerns and complaints

The practice had a complaints policy in place and a summary of this was contained in the practice's leaflet and displayed at the reception desk. The complaints policy was available in English and the practice staff informed us they could provide an alternative format if required. There had been one complaint since the practice registered with the CQC, and we saw this had been dealt with appropriately. Patients we spoke with told us they had no complaints and would know how to complain if they had to.

Are services well-led?

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

Summary of findings

The practice had arrangements in place to ensure a well-led service was provided.

There was an established management structure in place with clear delegation of tasks and responsibilities for both clinical and non-clinical staff. Staff we spoke with felt valued and supported by management in relation to their roles and training.

Governance arrangements including risk and performance management enabled the provider to monitor and improve co-ordinated care pathways for people using the service. The practice had effective systems in place to identify and manage risks, and improve the service.

Our findings

Leadership and culture

Staff we spoke with felt the practice was well led in that they were clear about their responsibilities and how this supported the philosophy of the service. This included having a team approach to patient care and monitoring the service provided to ensure it met current standards of excellence. An open and honest culture was promoted through formal and informal practice meetings to encourage staff engagement and involvement. Most of the staff members had been employed in their role for over six years therefore a consistency in care for patients had been maintained.

Governance arrangements

The GP was primarily responsible for governance arrangements and this included participating in external peer reviews, use of clinical audits as part of performance management and facilitating joint working arrangements with other professionals. The GP had access to peer support from other colleagues within the local Clinical Commissioning Group area and regularly attended multi-disciplinary meetings known as network learning forums.

One external colleague commented in an independent survey undertaken in June 2013 that the GP was an "Excellent leader of her team, outstanding care for patients who have a high prevalence of chronic disease and loyal and supportive colleague within the local medical community".

Systems to monitor and improve quality and improvement

The practice had systems in place to assess and monitor that high quality care was delivered. This included the use of suggestion boxes to seek patient views of the services provided, learning from complaints, significant events / incidents and clinical audits to improve patient health outcomes. The practice also participated in the 2013/14 Quality Outcomes Framework (QOF) scheme. This scheme assesses GP practices for levels of achievement against a range of clinical and non-clinical indicators. The achievement report dated 31 March 2014 showed the practice had achieved maximum points in 12 out of 19 clinical indicators. These included treatment and care related to heart failure, asthma, dementia, cancer and epilepsy.

Are services well-led?

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

Patient experience and involvement

The practice had an active Patient Participation Group (PPG) to ensure that patients' views about the service were taken into account. Records showed the Patient Participation Group comprised of members from most of the practice's ethnic group and plans were in place to engage further representation from male patients and younger age groups to ensure most population groups were represented.

The key achievements of the Patient Participation Group included the introduction of a practice newsletter, medication passport and completion of a patient feedback survey. The Patient Participation Group report that we looked at stated "most patients expressed a high level of satisfaction with their overall experience with the overwhelming majority rating their experience as excellent".

Staff engagement and involvement

Staff told us they felt respected, valued and were actively involved in decisions about the practice. Staff described the culture of the service as "open" and "one happy family". Both clinical and non-clinical staff attended the weekly practice meetings and minutes were made available to staff who were unable to attend.

Learning and improvement

The practice maintained a record of significant events and relevant medical safety alerts as part of assessing and monitoring the quality of services provided. These records included details of the identified areas of concern and risks, a route cause analysis, changes implemented as a result of the learning and external agencies informed of the incident. Examples of investigated incidents related to information governance and medication prescription errors; and we saw that appropriate changes were made to protect patients against the risks of unsafe care.

Some of the practice meeting minutes we looked at showed the outcome and learning from the significant event analysis had been discussed with staff and shared with external stakeholders involved. All the staff we spoke with told us there was an open culture within the service to discuss when things went wrong and improvement strategies were implemented to ensure patients received safe care.

Identification and management of risk

The practice had effective procedures in place to enable the management team to anticipate and minimise identified risks. For example, management plans were in place to mitigate potential safety risks related to the continuity of the service. This included disruption to staffing levels, utilities such as electricity and access to the premises.

Older people

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

Summary of findings

The practice had arrangements in place to meet the needs of older people.

Patients we spoke with told us staff were caring, responsive to their medical needs and treated them with respect. We found older people with long term conditions had their care coordinated by the GP practice together with professionals such as the district nursing and palliative care teams. Written information relating to age-related conditions such as Dementia and support groups was available for older people to access.

Our findings

All the patients we spoke with were complimentary of the services they had received and felt involved in decisions about their care. Patient leaflets were available in the reception area signposting older people to services that promoted care for specific diagnosis such as Dementia, Alzheimer's and carer support groups. The practice had protocols in place for the identification of carers and signposting them to resource centres within the local community and / or social services. Systems were in place to remind older people of medical reviews and general health checks to ensure they maintained good health. Home based appointments were available for older people who could not access the GP practice in person.

The GP attended Coordinate my Care training in May 2013. This informed the GP's practice to coordinate care in people's preferred place of death and to respect Do Not Resuscitate decisions made. The GP visited patients that had been discharged from hospital and developed appropriate care plans to avoid further admission. The practice also referred older people to the rapid response service if they were identified as being at risk of a hospital admission. The practice worked together with multi-disciplinary professionals and community services to ensure older people received appropriate assessment, planning and delivery of care.

People with long term conditions

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

Summary of findings

The practice had arrangements in place to meet the needs of people with long health conditions.

The practice worked in collaboration with providers of community health care services and secondary care to ensure that coordinated and multi-disciplinary care planning and review took place. Clinical audits were used to reflect on the appropriateness of referrals and / or treatment provided to patients using the service. People with long- term conditions were signposted to services such as counselling and support groups for carers to ensure their emotional needs were met.

Our findings

The practice had systems in place to promote an integrated model of care for people with long term conditions. This included: participating in multi-disciplinary meetings with professionals such as the district nurse / matron and palliative care team; external peer group meetings within the local Clinical Commissioning Group area; and signposting people to support groups related to their specific needs including their carers.

Where appropriate, referrals were made to community services related to dermatology, musculoskeletal conditions and diabetes management to avoid inappropriate outpatient referrals for example. The practice leaflet and newsletter also contained information on community resources patients could access including out of hours services.

Meeting records we looked at showed staff had received guidance on appropriate care pathways for the needs of this population group and were aware to seek clinical advice when concerned. The practice maintained risk registers related to specific long term conditions to inform the regular review of people's care. For example, a heart failure register was maintained of which some patients were referred to the heart failure nurse for routine visits and where appropriate the rapid response team were involved.

An audit had also been completed to identify and monitor the number of patients with a care plan in place, an end of life advanced care plan and needing case management. This included on-going monitoring of blood test results and repeat prescriptions for medicines such as warfarin in line with British National Formulary recommendations. This ensured people with long term conditions received appropriate care and treatment to meet their needs.

Mothers, babies, children and young people

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

Summary of findings

The GP practice provided services such as baby immunisations and six weekly health checks; and patients in this population group could access community services such as baby clinics and family planning services within the health centre.

The GP practice provided a safe, caring, responsive and well led service in collaboration with the hospital paediatric team, health visiting team, local authority and other GP practices within Queens Park Health Centre.

Our findings

Staff we spoke with had received safeguarding training and were aware of the procedures in place to refer vulnerable mothers, children and young people should concerns of abuse be identified. The practice had an enhanced access system where priority was given when booking appointments for children less than five years, in addition to extended surgery hours on Mondays. This ensured the health and social care needs of this population group could be met in a timely manner.

Records we looked at showed there were established multi-disciplinary working between the GP practice, health visitors and social workers to review and monitor concerns related to this population group. Childhood immunisations were administered by the practice nurse in line with national guidelines.

The GP undertook a clinical audit of paediatric referrals to establish the treatment received as an outpatient, number of follow-up appointments attended and reflected on the appropriateness of the referral to improve the health outcomes for children and young people using the service. The GP also referred children to the rapid access paediatric clinic in the community where appropriate, and reviewed hospital discharge summaries to inform discussion with parents regarding appropriate care pathways.

Working age people (and those recently retired)

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

Summary of findings

The practice had arrangements in place to meet the needs of this population group.

We found people were treated with dignity and respect when visiting the practice and they were involved in making decisions about their treatment. Patients told us they had no problems arranging appointments which suited them and suitable arrangements were in place to obtain emergency appointments. Patients had access to the practice information leaflet and notice board which detailed the different services available to them. Clinical audits were used to risk assess and manage health outcomes for patients using the service.

Our findings

Patients we spoke with felt that their rights and dignity had been preserved and they received good care. The appointment system was described as being easily accessible with non-urgent appointments being made available within 48 hours on most occasions. Health promotion advice and checks such as smoking cessation and smear tests were provided including relevant reading material.

Clinical audits reviewed showed that people's needs were assessed, treatment was delivered and monitored. This included sharing information with multi-disciplinary professionals to ensure the GP remained up to date with people's conditions and that they received treatment appropriate to their needs. Patients we spoke with told us they were involved in making decisions about their care and treatment, and had no complaints regarding the service provision.

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

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

Summary of findings

The practice had arrangements in place to meet the needs of people in vulnerable circumstances.

The practice supported patients to access primary care by maintaining them on their practice list and where appropriate, reviewed their care even though they were homeless or moved outside of the area. Patients in this population group were supported to access health promotion advice and external services from voluntary and statutory organisations in relation to their social care needs.

Our findings

The primary group of vulnerable people receiving services at the GP practice comprised of homeless people and people with learning disabilities. Records we looked at showed the GP referred homeless people to voluntary organisations for food vouchers to ensure their basic need for food was provided. Where concerns were noted in relation to their social needs appropriate referrals were made to housing and / or the local authority.

Staff we spoke with understood that people in vulnerable circumstances can be subject to abuse and demonstrated awareness of what action to take if they needed to raise a safeguarding alert.

The practice undertook annual reviews of the medical needs and care planning for people with learning disabilities together with their carers; and referrals to dentistry were also made. Health promotion advice was provided for people dependant on alcohol to inform their decision making to minimise / stop the intake.

People experiencing poor mental health

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

Summary of findings

The practice had arrangements in place to meet the needs of this population group.

The practice provided a safe, effective and caring service for people experiencing mental health problems. This included liaison with mental health professionals and referrals to community services to prevent people from experiencing a mental health relapse.

Our findings

The GP held regular discussions and meetings with the mental health nurse assigned to the practice to ensure the coordination of effective and safe care for people with mental health needs. This included the review of prescribed / repeat medication and sharing information about the admission and / or discharge of people with mental health.

People with mental health needs were also referred to voluntary organisations and NHS Improving Access to Psychological Therapies (IAPT) for further treatment and support groups where appropriate. The GP was aware of the principles of the Mental Health Act and the need to consider best interest decision making for people unable to consent to care and treatment in line with the Mental Capacity Act.