St Johns Wood Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Johns Wood Medical Practice on 25 November 2014. Overall the practice is rated as Good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and well-led services. It was also good for providing services to the six population groups we looked at: 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);

We found the practice requires Improvement for providing safe services.

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 areas of practice where the provider needs to make improvements.

Summary of findings

Importantly, the provider must:

- Ensure recruitment and training records are fully completed 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.

In addition the provider should:

- Record in the minutes of governance meetings evidence of discussion of and the communication of lessons learned from, significant events and complaints.
- Arrange for all staff to receive formal training in safeguarding of vulnerable adults and ensure the child protection training planned for administrative staff not currently trained is completed.
- Ensure the assurances provided to the local PHE/NHS England immunisations coordinator are adhered to and the policy for ensuring medicines were kept at the required temperatures is followed at all times.
- Monitor the updated automatic protocol for the management of patients who have been prescribed high risk medicines to ensure the records of reviews and action taken were fully completed.
- Review the practice's consent policy to ensure mental capacity was appropriately taken into account and take steps to raise staff awareness of how the policy applied to children aged under 16 who have the legal capacity to consent.
- Communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure in the staff appraisal process, learning and professional development needs were clearly linked to the appraisal review in all cases.
- Systematically review all practice policies and procedures, including the practice's business continuity plan, 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?

Requires improvement

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 always implemented well enough to ensure patient safety.

The practice had a system in place for managing significant events, incidents and accidents. We were told there was an annual practice meeting to review significant incidents where lessons learned were identified and discussed. The note of the annual review meeting held on 17 December 2014 was submitted to us after the inspection. However, we did not see evidence of on going shared learning from significant incidents and events throughout the year in the minutes of other meetings, held outside of the annual review meeting.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE).

The practice had appropriate safeguarding policies in place for both children and vulnerable adults. We found that staff knew how to recognise signs of abuse in vulnerable adults and the process to follow in the event of any safeguarding concerns. However, the majority of staff had not completed formal training in safeguarding of vulnerable adults.

The policy for ensuring medicines were kept at the required temperatures was not always followed in full and we identified potential breaches. Following the inspection the practice raised this with the local PHE/NHS England immunisations coordinator who was satisfied with the actions that the practice had taken and did not feel this needed to be classified as a serious incident.

There was a system in place for the management of patients who had been prescribed high risk medicines. However, the records for this were not always fully completed. Immediately after the inspection the practice submitted details of extra automatic computer alerts introduced to improve recording of data.

There were robust infection control policies and procedures in place.

The practice had a policy for recruiting staff, including the required pre-employment checks. There was no documentary evidence available on the day of the inspection relating to the recent

Summary of findings

appointment of a new GP partner and limited information in relation to a locum doctor. However, since the inspection the practice has shared with us pre-employment checks undertaken for the partner GP.

The practice had appropriate systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice, including arrangements to manage emergencies.

Are services effective?

Good

The practice is rated as good for effective. The practice scored positively in their QOF performance and used QOF to steer practice activity. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. The practice participated in clinical audit and routinely collected information to review and improve patient care and outcomes. The practice worked in collaboration with other health and social care professionals to provide a multidisciplinary approach to their care and treatment. The practice had a consent protocol which staff were aware of and followed. However, the policy did not make reference to mental capacity and not all staff demonstrated clear knowledge of how the policy applied to children aged under 16 who have the legal capacity to consent. There were arrangements in place to support staff appraisal, learning and professional development, although it was not always clear how learning and development needs were linked to appraisal. Due to a change in management there had been a slight delay in staff appraisals and a central record of staff training was being developed. However, staff learning and development needs had been discussed and agreed and staff had continued to undertake relevant training. The practice fostered good health promotion and prevention.

Are services caring?

Good

Data from the national GP patient survey showed the practice was rated above the CCG average for care and concern and on consultations with doctors and nurses. Scores from the practice's own patient survey showed overall there was a high degree of satisfaction with the medical staff, medical services, administrative staff and premises. 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 and involved them in decisions about their care and

Summary of findings

treatment. We observed during the inspection that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the needs of its patients and was responsive to these. Data from the national GP patient survey showed the practice was rated above average in the CCG area for convenience, experience of making an appointment and waiting times but below average for being able to see or speak to their preferred GP. The views from patients we spoke with and who completed our CQC patient comment cards were mostly positive about access to the service. The practice had taken a number of steps to improve accessibility in the light of feedback. There was an effective complaints system, although information about the complaints procedure was not readily available to patients in the waiting area. Staff we spoke with understood the complaints procedure and confirmed that any learning from complaints was discussed with them. However, we did not see documentary evidence to confirm that lessons learned had been communicated throughout the practice, for example, at practice meetings. The premises and services had been adapted to meet the needs of people with disabilities.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service. The practice's aims were set out in its statement of purpose. Although not all staff were aware of the statement, they were able to articulate the essence of these aims. There was a clear leadership structure with named members of staff in lead roles. There was an open culture, staff were clear about their own roles and responsibilities and felt supported in their work. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice had a range of policies and procedures to govern activity. However, there was no formal schedule for their regular review and many had not been reviewed for a number of years and others were undated. The practice had arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, the document was in need of review as it had not been updated for some time. The practice had an ongoing programme of

Summary of findings

regular governance meetings. Staff had received induction training and regular performance reviews. The practice proactively sought feedback from staff and patients, including a patient participation group (PPG) which it acted on.	

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. 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 and the practice ensured that patients at greatest risk were in contact with a care navigator and community matron, backed up by the district nursing team. The practice had close links with the district nurses who were based within the premises. Regular and one-on-one "open door" meetings were held with them to discuss patient care for housebound and vulnerable patients. Each patient over 75 had a named GP, which could be changed if the patient requested it. They also had care plans which were actively added to and updated as circumstances changed. For older patients and patients with long term conditions home visits were available and patients were encouraged to ask for these. Screening took place of older patients attending for flu vaccinations to assess whether they were experiencing memory problems. Follow up screening was arranged where appropriate. There were appropriate and effective end of life care and bereavement support arrangements in place.

People with long term conditions

Good

The practice is rated good for the care of people with long term conditions. The practice provided services for patients with diabetes, asthma, hypertension and chronic obstructive pulmonary disease (COPD). Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance. All patients with one or more long term conditions were proactively recalled using a computerised recall system and also opportunistically during consultations. There were also automatic protocols to ensure the practice checked blood glucose annually in patients with a diagnosis of gestational diabetes or impaired glucose tolerance (IGT). Patients with repeat prescriptions were audited annually and asked to see a doctor to review their medication. Flu and pneumococcal vaccinations were offered to patients in at risk groups, including patients with long term conditions. The practice was looking at ways to increase coverage of flu vaccinations to the under 65 group with long term conditions, for example by text messaging. For patients with long term conditions home visits were made by district nurses and GPs and longer appointments were provided when needed.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided contraception and sexual health services including contraception advice and emergency contraception, and smear testing. The practice's performance for cervical smear uptake was 78.7%, which was above the CCG average. The practice offered a full range of immunisations for children. Flu vaccination was offered to pregnant women. There were procedures in place to safeguard children and young people from abuse. Both clinical and non-clinical staff had received child protection training in line with national guidance, although training was being arranged for six administrative staff (including four recently appointed). The practice kept a register of patients with families and children at potential risk. There were regular meetings with health visitors to review at risk children and families. The practice had recently joined with the paediatric team from a local NHS acute hospital and held monthly paediatric clinics for specific patients, followed by a monthly multidisciplinary team meeting with a neighbouring practice. The practice ran weekly ante and post natal clinics and a mother and baby clinic. Health visitors held regular one to one and group clinics. Patients with children had access to mother and child parking, pram parking a children's play area, a parent and baby room and baby changing facilities.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was accessible to working people. For example, nursing appointments commenced at 8.00am and first GP appointments were at 8.20am. There was a spread of appointments until 6.10pm with weekend GP appointment availability at a neighbouring practice. Telephone advice was available throughout the day by the doctors and nurses and the practice tried to ensure that this was at times that suited its working population. The practice offered a full range of health promotion and screening which reflected the needs for this age group. Health and exercise advice was given at routine appointments. Appointments could be booked on line and repeat prescriptions ordered electronically. The practice identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There was an open door policy and vulnerable groups such as the homeless and street sex workers could register, although none were on the practice's register

at the time of the inspection. Drug users were referred to appropriate services locally. The practice kept a register of all patients with a learning disability and routinely recalled them to check their physical health, acquaint them with any health promotion from which they would benefit and to check changes in their social circumstances. Patients with learning disabilities were offered longer appointments to facilitate this. Staff knew how to recognise signs of abuse in vulnerable adults and the process to follow in the event of any safeguarding concerns. However, the majority of staff had not completed formal training in this area. If needed, translation services were available for patients who did not have English as a first language. The premises and services had been adapted to the needs of patients with a disability.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had access to cognitive behaviour therapy (CBT) counsellors in house and locally. Counselling and CBT took place at the practice weekly. The practice also referred patients to the Central North West London (CNWL) Assessment and Brief Treatment (ABT) team and outreach services, including a primary care mental health worker each week to see patients in a more familiar setting. The practice also 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. A primary care mental health worker was available on site once a week to provide counselling and psychology services and patients were referred by their GP. Regular reviews and medication management plans and recall protocols were in place for patients on high risk medicines, including medicines for patients with mental health conditions.

Summary of findings

What people who use the service say

We received 21 completed Care Quality Commission (CQC) comment cards providing feedback about the service. On the day of our inspection we also spoke with 11 patients, including three representatives of the practice's patient participation group (PPG). The majority of patients were positive about the service experienced. Patients felt the practice was safe, clean and hygienic. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

These comments were reflected in the national patient survey 2013/14 where the practice scored above the CCG average for patient satisfaction for being treated with care and concern and for satisfaction with consultations with the doctor and nurses. A minority of patients were less positive raising issues mainly about the time taken for the telephone to be answered and delays in booking an appointment with a named doctor.

Members of the PPG we spoke with echoed the mostly positive views expressed by other patients and felt the group was beneficial to and actively involved with the practice. We looked at the patient survey of 236 patients conducted through the group for 2013/2014 and saw that overall there was a high degree of satisfaction with the medical staff, medical services, administrative staff and premises. Respondents felt doctors were caring, patient and professional. The results of the survey indicated that some patients would like: the surgery to be open during evenings and weekends; to see their GP instead of someone else or a locum; and to see a GP within 3 weeks. They also said they had too long a wait whilst in the surgery and did not get to see the same GP consistently. These issues were included in the action plan from the survey and were subject to ongoing discussion and review within the practice and at PPG meetings.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment and training records are fully completed 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.

Action the service SHOULD take to improve

- Record in the minutes of governance meetings evidence of discussion of and the communication of lessons learned from, significant events and complaints.
- Arrange for all staff to receive formal training in safeguarding of vulnerable adults and ensure the child protection training planned for administrative staff not currently trained is completed.
- Ensure the assurances provided to the local PHE/NHS England immunisations coordinator are adhered to and the policy for ensuring medicines were kept at the required temperatures is followed at all times.
- Monitor the updated automatic protocol for the management of patients who have been prescribed high risk medicines to ensure the records of reviews and action taken were fully completed.
- Review the practice's consent policy to ensure mental capacity was appropriately taken into account and take steps to raise staff awareness of how the policy applied to children aged under 16 who have the legal capacity to consent.
- Communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure in the staff appraisal process, learning and professional development needs were clearly linked to the appraisal review in all cases.

Summary of findings

- Systematically review all practice policies and procedures, including the practice's business continuity plan, to ensure they remain up to date and relevant.

St Johns Wood Medical Practice

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 St Johns Wood Medical Practice

St Johns Wood Medical Practice provides primary medical services through a General Medical Services (GMS) contract to around 12,600 patients in the St Johns Wood, Primrose Hill, Maida Vale areas of North West London. The practice has an open list, increasing by net 5-600 per annum (25 new registrations on average per day). The patient population includes a cross-section of socio-economic and ethnic groups. There is a spread of age groups served by the practice of which about 8.2% are children under 5, 12.7% over 65, 7.2% over 75 and 2.6% over 85. There are above average numbers in the 25-44 age group.

The practice is based within The Hospital of St John & St Elizabeth in St Johns Wood and has access to services at the site including cleaners, porters, maintenance and St Johns Hospice.

The practice team is made up of six GP partners, a locum GP, the practice manager, reception manager, two part-time nurses, a health care assistant, two part-time administrative staff, a practice secretary and eight part-time reception staff. Three of the GP partners are male and three female.

Appointments are available from 8:00am to 6.30pm Monday, Tuesday, Wednesday and Friday and 8:00pm to 1:00pm and 2:00pm to 6:30pm on Thursday.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice had out-of-hours (OOH) arrangements in place with an external provider. Patients could also visit a neighbouring practice in Maida Vale at weekends. They were advised that they could 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.

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 that we hold about the practice and asked other organisations to share what they knew. We liaised with Central London (Westminster) Clinical Commissioning Group (CCG) Westminster Healthwatch and NHS England.

We carried out an announced visit on 25 November 2014. During our visit we spoke with a range of staff including four GPs, a nurse, health care assistant, the practice manager, an administrator and two reception staff. We also spoke with 11 patients who used the service, including three members 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 the personal care or treatment records of patients. We reviewed 21 CQC 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.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. In one case discrepancies were found in a patient's notes where another patient's information had been summarised alongside the actual patient's details. The incident was discussed within the practice and the summarising policy was updated to emphasise the importance of checking that notes worked on were for the relevant patient.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events and details of these was made available to us before the inspection for events that had occurred during the last two years. These records provided a summary of the event, the action taken and the learning outcomes. Staff we spoke with told us the outcomes of significant events were discussed with them. We were told there was an annual practice meeting to review significant incidents where lessons learned were identified and discussed. The note of the annual review meeting held on 17 December 2014 was submitted to us after the inspection. However, we did not see evidence of on going shared learning from significant incidents and events throughout the year in the minutes of other meetings, held outside of the annual review meeting.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw records were completed in a comprehensive and timely manner which included suggestions to prevent recurrence and specific action required. The practice informed NHS England of incidents of potential patient harm. For example, due to a misunderstanding a member of staff deleted a patient consultation from their record. The practice manager reviewed the incident and the deleted consultation was reinstated on the patient's record. The incident was discussed within the practice and it was made clear to all staff that nothing should ever be deleted from a patient's record.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The practice manager and a nominated GP lead were responsible for reviewing and distributing any alerts and guidelines to staff within the practice. For example, we saw evidence that the practice had acted on MHRA drug safety alert in relation to an antibiotic used to treat urinary tract infections. Patients affected by the alert were identified to ensure the advice contained in the alert was followed in their treatment.

Reliable safety systems and processes including safeguarding

The practice had appropriate safeguarding policies in place for both children and vulnerable adults, including contact details for local safeguarding agencies. The practice had a nominated GP lead for safeguarding and staff we spoke with knew who the lead was, how to recognise signs of abuse and the process to follow. Details of local safeguarding contacts were available to staff in the reception area. However, not all staff we spoke with were aware of this information. We were shown certificates for safeguarding children training which staff had undergone. These showed that nursing staff received training at Level 2 and GPs at Level 3 in accordance with national guidance. Administrative were trained at level 1. However, the certificates were not available for two of the nursing staff and one of the GPs. Six administrative staff (including four recently appointed) had not received child protection training but we were told this was being arranged. In addition, apart from the safeguarding GP lead, neither clinical nor administrative staff had completed formal training in safeguarding of vulnerable adults.

The practice kept registers of patients with learning difficulties and families and children at potential risk. This included information to make staff aware of any relevant issues when patients attended appointments. There were quarterly meetings with health visitors to review at risk children and families. In addition the practice held separate safeguarding meetings to ensure that the register for vulnerable families was updated and that clinicians and health visitors all had the appropriate information.

Requires improvement

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard but was not displayed in all consulting rooms we visited. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told some reception staff occasionally acted as a chaperone if nursing staff were not available. All those acting as a chaperone had undergone a criminal records check. No staff had received formal chaperone training at the practice but they understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Practice staff, were aware of the action to take in the event of a potential power failure. However, we saw that some records did not reflect the action that was described to us. The practice told us that they had sought suitable advice for managing their refrigerators when temperatures had gone outside the required range but this had not been recorded. Immediately after the inspection the practice raised the matter as a clinical incident and contacted the local screening and immunisation team in NHS England for further support and advice, with reference to national guidance from Public Health England (PHE) vaccine storage. The PHE immunisations coordinator was satisfied with the actions that the practice had taken and did not feel this needed to be classified as a serious incident.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with clinical waste regulations. There were no controlled drugs kept at the practice.

The practice nurses were not qualified as nurse prescribers, so patient group directives (PGDs) were in place in line with legal requirements and national guidance. PGDs allow specified health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. All the necessary PGDs were signed as required and a folder was kept at the practice containing up to date directives. For example, the nurses and the health care assistant administered vaccines using these directives and these staff had received appropriate training to administer vaccines.

There was a system in place for the management of patients who had been prescribed high risk medicines which included regular monitoring to comply with national guidance. The practice said there were regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions. However, in two patient records we looked at the monitoring of rheumatoid arthritis medicines had not been fully completed. We were told this was because the automatic protocol for this was held on the previous computer system and had not yet been set up on the new system which had been introduced in the practice earlier in the year. Immediately following the inspection, the lead GP for medicines completed the protocol and provided evidence of how the protocol worked. However, we cannot judge the effectiveness of this without seeing the impact on patients of the improved monitoring put in place.

The practice had a system set up with a local pharmacy to supply patients with blister packs of medicines to support patients with memory problems.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning services were run by the host provider and we saw there were cleaning schedules in place and cleaning records were kept. The cleaning service was also called to handle ad hoc issues, such as spillages. The host provider's cleaning manager carried out quarterly spot checks on cleaning standards. The practice manager also liaised with the cleaning supervisor to report and arrange for day to day issues to be addressed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had clinical and administrative leads for infection control. They also had access to the host provider's infection nurse who visited the practice to review ad hoc infection control issues and provide advice on infection control policy. All staff received induction training about infection control specific to their role and received

annual updates. We saw that annual infection control audits were carried out by the CCG and any improvements identified for action were completed on time. We saw the action plan from the most recent audit and noted that the action identified had been implemented. One action was on going to replace open shelving with cupboards when next refurbishing. A further audit was due the day after the inspection.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff felt they were well supported in this respect. Staff were able to describe how they complied with the practice's infection control policy when treating patients and in the cleaning and disinfecting regime they followed between patient appointments. There were disposable privacy curtains in treatment rooms which we were told were replaced every six months. There was no date on the curtains showing when they were installed but the practice manager kept a record of this and ensured curtains were renewed when needed. There were occupational health arrangements in place to ensure that all relevant staff were protected against Hepatitis B. We saw the record of immunisation status which showed immunisation for relevant staff was up to date, apart from recently appointed staff for whom arrangements for checks were due to be made.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice underwent regular assessments for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw the certificate of the latest assessment carried out by the host provider, dated 20 March 2014, which confirmed the practice was legionella free.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. 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 we saw equipment displayed stickers and the certificate indicating the last test was dated September 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, hand held ultrasound devices, pulse oximeters, ear syringes and the vaccine fridges.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We spoke with a recently recruited member of staff who confirmed that the recruitment policy had been applied appropriately on their appointment. Records of recent administrative staff recruitment we looked at contained evidence of interview and selection decisions and confirmed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and criminal records checks through the Disclosure and Barring Service (DBS). There was no documentary evidence available on the day of the inspection relating to the recent appointment of a new GP partner and limited information in relation to a locum doctor. However, since the inspection the practice has shared with us pre-employment checks undertaken for the partner GP including a criminal records check, GMC registration, confirmation of status on the Medical Performers List and professional indemnity insurance.

We were told about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs and that this was constantly reviewed. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also arrangements in place for members of staff, including doctors, nursing and administrative staff, to cover each other's annual leave and during sickness. Locum doctors were used as required. At the time of our inspection a locum was employed to cover maternity leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Some mentioned that more staff were needed to meet the workload and they welcomed the forthcoming

appointment of additional staff in December 2014. The practice told us that its patient list size was increasing year on year and currently on average they were taking on 25 new registrations a day. In response, the practice was increasing the number of administrative/ reception staff and taken on an additional GP partner and nurse. The additional appointments were expected to ease the workload and address periodic backlogs that had arisen including document scanning and summarising of patients' notes. In particular a notes summariser had been appointed and we were told the backlog was being cleared and any outstanding clinical issues followed up with clinicians.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy, although this had not been reviewed for some time and required updating to reflect current circumstances. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice had access to the host provider's hospital estates team who we were told responded to repairs on the same day.

We saw the report of the most recent health and safety risk assessment carried out in October 2014. We noted implementation of the action plan had been initiated. We were also provided with copies of reports of Control of Substances Hazardous to Health (COSHH) assessments carried out in the last year. These covered infectious micro-organisms, oxygen and liquid nitrogen. The reports indicated that the assessments had been discussed with staff and action plans implemented.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, the practice had regular one on one communications with a care navigator identifying those at risk using a risk stratification tool and potentially vulnerable patients recently discharged from hospital so that the right services were accessed and available.

We saw that the practice was able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, the practice was ensuring that patients over the age of 75 who were at greatest risk were in contact with the care navigator and community matron, backed up by the district nursing team. All patients with one or more long term condition were proactively recalled using a computerised recall system and also opportunistically during consultations. The practice had systems in place to monitor families and children at risk. Registers were kept of patients with learning difficulties and staff had been trained to look for signs of abuse within vulnerable families and the action to take if concerns were raised. Screening took place of older patients attending for flu vaccinations to assess whether they were experiencing memory problems. Follow up screening was arranged where appropriate, for example for blood and urine test, and an appointment with the GP and hospital referral if required.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff received training in basic life support organised by the host provider. Emergency equipment was available including access to oxygen a pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice had access to the host provider's on-site crash team and paediatric and adult crash trollies containing emergency equipment and medication were located within the practice. These were maintained and inspected by the crash team.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, the document was in need of review to ensure all potential risks were rated and mitigating

Requires improvement

Are services safe?

actions recorded to reduce and manage the risk, including risks such as power failure, IT system failure, adverse weather, unplanned sickness, staffing changes and access to the building.

The host provider carried out regular fire risk assessments for the hospital site that included actions required to maintain fire safety in the practice. The on-site team provided fire safety training (including fire warden training). Practice staff were up to date with this training, apart from newly appointed staff who were due the training. The host provider carried out weekly fire alarm testing and arranged periodic fire evacuation drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs and nursing staff kept up to date with and acted on relevant professional guidance through continuing professional development, NICE guidelines, patient safety alerts and other sources such as professional journals. We were told that new guidelines and alerts were discussed at weekly clinical practice meetings including the implications for the practice's performance and the action required for individual patients. For example, the recent NICE guidelines on the lowering of the threshold for statins use in adults at risk of heart disease. There were also weekly education meetings to update clinicians on the latest guidance.

The GPs we spoke with told us they had special interests in a number of clinical areas including minor surgery, diabetes, paediatrics, obstetrics, gynaecology and women's health, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines to support the effective assessment of patients' needs.

The practice showed us benchmarking data from the local CCG of the practice's performance for antibiotic prescribing under the CCG prescribing incentive scheme between quarters two and three of 2014-15. This showed the practice compared favourably with other practices in the reduction of antibiotic use. The practice used computerised tools to identify patients with complex needs who required recall for a review, for example those with long term conditions such as chronic obstructive pulmonary disease (COPD), and osteoporosis. There were also automatic protocols to ensure the practice checked blood glucose annually in patients with a diagnosis of gestational diabetes or impaired glucose tolerance (IGT).

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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 and carried out regular clinical audit. 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 showed the practice performed above other practices in the local CCG area in the majority of indicators in the year 2013/2014.

We noted that the practice performance in the QOF reports for 2013-2014 showed a total of 97.6 % of QOF points achieved in the clinical domain which was 13.1% above the CCG average. We noted that for the majority of these indicators the practice achieved a score above the CCG average (100% in several areas) and for one indicator only, learning disability, 10% below the CCG average, which the practice was keeping under review. Within the domains of public health, quality and productivity and patient experience, all the practice scores were above the CCG average apart from one which was equal to it.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits undertaken in the last 12 months included audits of the use of medicine used to treat pain and inflammation associated with arthritis and an antibiotic used to treat urinary tract infections following MHRA alerts. Some actions for improvement had been identified as a result of these audits. For example, in the first case the practice searched its database to find all the patients to whom they were prescribing the medicine. They identified 60 patients and sent them the letter informing that the medicine may cause a small increase in the risk of heart disease and stroke and inviting them to an appointment with their regular doctor to review their treatment to see if an alternative drug may be more appropriate. At the same time they removed the medicine from the patients' repeat medicines list. This was followed

up by a repeat search four months later that showed that they were now prescribing the medicine to only 5 patients. These five patients had all tried an alternative medicine and expressed a wish to revert to the original medicine.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. Repeat prescriptions could be ordered, by fax, online or in person at the practice. Patients were asked to allow two days for repeat prescriptions to be processed before collection. Patients with repeat prescriptions were advised that the practice would need to see them to arrange monitoring tests at regular intervals, and to look out for instructions with the prescription and keep their checks up to date. There was a yearly audit of patients on repeat prescriptions who had not responded and whose medicines review was overdue to ensure patients did not 'fall through the net'. There were alerts in the patient records system to ensure reviews took place. For example, the practice had a protocol to warn if they had not checked urea and electrolytes for patients on ACE inhibitors or ARRAs (medicines that are used mainly in the treatment of high blood pressure (hypertension) and heart failure). Another example was a protocol to warn of over use of reliever inhalers for asthmatics. If more than six inhalers were requested there was an alert on the record system to invite the patient for an urgent review.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, CCG data showed that between April 2013 and March 2104 the annual A&E attendance rate for the practice was below the CCG average for all attendances and also for non-elective admissions. The practice reviewed attendance rates monthly to consider the appropriateness of attendances and agree follow up action with patients concerned.

We saw the notes of the partners' review of A&E attendances dated November 2014, which concluded that the majority of attendances were appropriate. It also recorded follow up action with the community matron in one case of inappropriate attendance which resulted in reduced attendances. A further review was set for a year's time. We were also shown the minutes of partners meeting in September 2014 to consider outpatient referrals, covering ophthalmology, dermatology and gynaecology. Learning points were discussed for the small number of inappropriate referrals identified.

The practice coded all referrals in patients' records for suspected cancer and ran searches to check that they had been seen in secondary care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. At the time of the inspection the practice manager was developing a new training matrix to plan, manage and keep under review staff training, which we were shown. There was therefore no up to date central record of staff training available. However, we saw certificates which showed staff were up to date with attending or mandatory courses such as annual basic life support, infection control and safeguarding children. In a small number of cases certificates were not available for safeguarding training. We noted a good skill mix among the doctors whose special interests covered a number of clinical areas including minor surgery, diabetes, paediatrics, obstetrics, gynaecology and women's health.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, wound management, contraception, tissue viability and anti-coagulation.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. However, we were told that due to a change in management there had been a slight delay in staff appraisals which would now be taking place in the New Year. The staff we spoke with said that they had received previous six-monthly appraisal reviews. Some said that they had had the opportunity to discuss and agree their personal learning and development needs and they had

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Are services effective?

(for example, treatment is effective)

continued to undertake relevant training throughout the year. However, one appraisal report we looked at did not show that training needs had been reviewed to link learning and development planning with the appraisal.

Staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to. The GP held quarterly practice meetings to discuss and review clinical and operational matters. We saw a sample of minutes of these meetings. There were also regular informal meetings to discuss on going issues, although these were not documented.

The practice had policies and procedures for managing poor performance but we did not see any evidence that there had been a need to activate these recently.

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.

The practice had access to cognitive behaviour therapy (CBT) counsellors in house and locally. Counselling and CBT took place at the practice weekly. The practice also referred patients to the Central North West London (CNWL) Assessment and Brief Treatment (ABT) team and outreach services, including a primary care mental health worker each week to see patients in a more familiar setting. The ABT provided an assessment of a patient's mental health needs, gave feedback, and offered time-limited treatment if appropriate. The practice also 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. A primary care mental health worker was available on site once a week to provide counselling and psychology services and patients were referred by their GP.

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 a GP on the same day and actioned. Results were usually received electronically. The practice provided an anticoagulation service twice a week using specialised dosing software for which staff had received relevant training. Phlebotomy was available at the practice throughout the day as they had two pathology collections a day for blood, urine and histology samples.

Health Visitors were based within the practice premises and the practice held regular and one-on-one meetings to ensure the clinicians were updated on the needs of under 5s. In addition the practice held separate quarterly safeguarding meetings to make sure that the register for vulnerable families was updated and clinicians and health visitors all had the appropriate data.

The practice had recently joined with the paediatric team from a local NHS acute hospital and held monthly paediatric clinics for specific patients followed by a monthly multidisciplinary team meeting with a neighbouring practice.

The practice had out-of-hours (OOH) arrangements in place with an external provider. Patients could also visit a neighbouring practice in Maida Vale at weekends. They 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.

The majority of referrals for hospital appointments were made through an external triage service. The purpose of the service was to ensure all patient referrals were directed to the most appropriate clinician. The practice also used the 'Choose and Book' system (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice had an effective process in place to follow up patients discharged from hospital. Discharge summaries were received electronically and were followed up by a GP. The practice had regular one on one communications with its 'care navigator' regarding potentially vulnerable patients recently discharged from hospital so that the right services were accessed and available.

The practice had close links with the district nurses who were based within the premises. Regular and one-on-one "open door" meetings were held with them to discuss patient care for housebound and vulnerable patients.

The practice provided effective end of life palliative care. The practice worked closely with the hospice based within

Good

Are services effective?

(for example, treatment is effective)

the host provider's premises for people receiving palliative care. There were quarterly multidisciplinary meetings with the hospice team to review patients on the practice's end of life care register and update information about them. We saw evidence from these meetings of care planning review for a patient receiving palliative care.

The practice was a member of national and local clinical research networks. At the time of the inspection the practice was taking part in three studies:

- A Helicobacter Eradication Aspirin Trial **(**HEAT) study. (Helicobacter, is a bacteria which causes ulcers);
- A Hypertension pathways study; and
- A Parkinson Disease research project.

The practice had also taken part in various campaigns, most recently the BCOC – Be Clear on Cancer, a Public Health England programme of activity, delivered in partnership with NHS England, Department of Health and Cancer Research UK. The aim of BCOC is to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and for International Normalisation Ratio (INR) results for patients on anti-coagulants.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice had moved to a new clinical system in the last year which we were told had caused the practice some disruption. They found the new system was not straightforward and reception/ administrative staff had taken time to get used to the new way of working. However, the practice felt that the situation was getting better and staff were gaining confidence with the system. Staff we spoke with confirmed this.

Consent to care and treatment

The practice had a comprehensive consent protocol which set out the practice's approach to consent; types of consent; obtaining consent**;** what information should be provided; recording consent; consent for children; obtaining written consent; and patient consent procedure forms. 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. The policy did not make reference to the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. GPs we spoke regard were aware of the Act with regard to mental capacity and best interest assessments in relation to consent. Nursing staff had a basic understanding but had not received training in this area.

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. Not all staff we spoke with demonstrated a clear understanding of Gillick competencies when asked about seeking consent. This meant that the service was not as accessible as it could be for patients to whom the 'Gillick Test' may apply. The test helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. We noted that where appropriate Gillick competence was recorded in free text on the consent form.

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 to the patient's notes.

We saw appropriate care plans in place for patients with dementia and learning disabilities. However, we did not see evidence that the patients or their carers had been involved in agreeing the care and treatment planned.

Health promotion and prevention

There was a good range of information available to patients in the waiting area which included leaflets which could be taken away from the practice. However, there was no information on display promoting the sexual health and contraception services provided in the well women and family planning clinics. There was, though, relevant information about these and other clinics and services on

Good

Are services effective?

(for example, treatment is effective)

the practice website. There were also links to the NHS Choices Website, and the most popular health subjects, including sections on family health, long term conditions and minor illnesses.

We were told that up until 2013 the practice achieved a high percentage of NHS health checks to patients aged 40 to 74. However, the practice felt the prescriptive way it was commissioned from 2013 did not suit their working age population and the checks had not routinely been offered for the past year. The practice still carried out risk assessments for cardiovascular disease and would be applying for a less prescriptive NHS check under a CCG local enhanced scheme (LES) to be rolled out from April 2015.

The practice had several ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and routinely recalled them to check their physical health, acquaint them with any health promotion from which they would benefit and to check changes in their social circumstances. All patients with one or more long term condition were proactively recalled using a computerised recall system and also opportunistically during consultations The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients.

The practice provided a family planning service, including fitting/removal of intrauterine contraceptive devices (IUCD) and birth control implants, and smear testing. The practice's performance for cervical smear uptake was 78.7%, which was 6 percentage points above the CCG average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. In 2013/14 there was an 80% uptake of flu vaccination offered to patients aged 65 and older, which was above the national average of 73%. The practice was looking at ways to increase coverage to the under 65 group with long term conditions, for example by text messaging. The practice's performance in providing immunisations for children was generally good for all three age groups covered, and upper targets were achieved.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14 and a survey of 236 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, in the national patient survey 95% of respondents rated the last GP they saw or spoke to, and 90% the last nurse they saw or spoke to, as good at treating them with care and concern,. Both of these ratings were above the CCG average. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 93% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time. The PPG survey asked different questions but overall there was a high degree of satisfaction with the medical staff, medical services, administrative staff and premises. Respondents felt doctors were caring, patient and professional.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. There were some less positive comments mainly about the time taken for the telephone to be answered and delays in booking an appointment with a named doctor. We also spoke with 11 patients on the day of our inspection, including three members of the PPG. All 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, we noticed there was an echo in the reception area which meant that some conversations with patients could be overheard. Staff told us they would take patients to a private area if necessary to maintain confidentiality.

The practice had a zero tolerance policy for abuse regarding any patient who is physically or verbally abusive or threatening towards staff or other patients. The policy was on display in the reception area.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 86% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Where it was known that a patient needed an interpreter this was flagged on the patient's record. We noted that the self-check in touch screen in reception was provided in the six most popular spoken languages related to the practice patient population. We saw also that the practice's website had a translation facility for each page in a wide choice of languages.

We saw evidence of care plans in place for older people. In one record we looked at the recorded input from the care navigator regarding the resolution of social care needs following the patient's discharge from hospital, alongside relevant input from the GP. In another case we saw relevant

Good

Are services caring?

updates made by the duty doctor, as a result of telephone call to follow up a patient's admission to hospital. We also saw appropriate information about end of life care planning for a patient receiving palliative care, following a meeting with the palliative care team.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with were positive about the emotional support provided. One patient who completed a comment card about the service told us that following a serious diagnosis they had been very well looked after by their GP who was always there when needed. We were told the duty GP was available to speak to patients in crisis.

Notices in the patient waiting room and on the practice's website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

For older people, the practice's care navigator ensured that those in need were contacted by voluntary and faith services, and other services such as the community COPD teams and wheelchair services.

The practice appropriately supported patients receiving end of life care. Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' 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 in the way services were delivered. The majority of patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and in most respects they were happy with the service provided.

The practice engaged regularly with the local Clinical Commissioning Group (CCG) at locality meetings The practice also had board membership with a new GP provider network to provide out of hospital services and to pool budgets with social services, two local NHS acute hospitals, the voluntary sector and community services. This enabled the practice to coordinate services provided by the local community healthcare trust, social services and the third sector.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Respondents had said that on occasion, more time was needed as some appointments felt rushed. Double appointments were now offered to older patients, those with learning difficulties and those whose first language was not English. Patients had also said they disliked early morning walk-in phlebotomy clinics due to long waits, so the practice switched to appointments only.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, although for urgent appointments this was not always possible. This was an area identified for improvement in the 2013/14 PPG patient satisfaction survey where patients had said they would like to see the GP of their choice instead of another GP or locum. This was reflected in the national patient survey 2013/14 where the practice scored 54% for patients with a preferred GP who usually get to see or speak to that GP. This was 4% below the CCG average. The practice had three male and three female GPs and a female locum doctor and was able to offer some choice of male or female doctor if this was requested.

Each patient over 75 had a named GP, which could be changed if the patient requested it. They also had care plans which were updated as circumstances changed. For older patients and patients with long term conditions home visits were available and patients were encouraged to ask for these to ensure that patients contacted their GP rather than wait until they were able to attend the practice.

The practice provided clinics for patients with long term conditions, for example, diabetes and asthma and a cardiovascular clinic for patients who were at risk from suffering high blood pressure and heart disease. The practice carried out spirometry tests to diagnose and monitor COPD and other lung conditions. 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, which identified patients due a review.

The practice ran weekly ante and post natal clinics and a mother and baby clinic. Health visitors held regular one to one and group clinics and this was seen as a good way for mothers to meet one another.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was an open door policy and vulnerable groups such as the homeless and street sex workers could register, although none were on the practice's register at the time of the inspection. Drug misusers were referred to appropriate services locally.

The practice had access to interpreter and translation services. Patients were encouraged to allow the practice to book interpreters if they needed them. Patients were also encouraged to ask for longer appointments if they had physical or language barriers that required more time, or if they had complex issues to discuss.

The practice had an equal opportunities policy. Staff read the policy as part of the induction process and were aware of patients' equality and diversity needs covering a diverse population of patients. However, they had not received specific equality and diversity training.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The premises and services had been adapted to the needs of patients with a disability. There was disabled parking and level access from the main entrance for wheelchair users. The practice had access to the host provider's hospital porter service to transport patients who lacked mobility. We saw that the waiting area had a hearing induction loop for patients with reduced hearing. 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.

Patients with children had access to mother and child parking, pram parking, a children's play area, a parent and baby room and baby changing facilities.

Access to the service

Appointments were available from 8:00am to 6.30pm Monday, Tuesday, Wednesday and Friday and 8:00pm to 1:00pm and 2:00pm to 6:30pm on Thursday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, telephone consultations and home visits and how to book appointments through the website. Longer appointments were also available for patients who needed them. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, a recorded message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The views of 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. One patient also raised a concern on the day of the inspection about the long waiting time for their appointment and the problems this caused due to work commitments.

Data from the 2013/14 national GP patient survey showed 87% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, which was above the CCG average. Ninety one percent said their last appointment was convenient and 79% described their experience of making an appointment as good. Seventy seven percent of respondents said they usually wait 15 minutes or less after their appointment time to be seen, which was 19% above the CCG average. However, 54% of respondents with a preferred GP said they usually got to see or speak to that GP (4% below the CCG average). Seventy six percent were satisfied with the surgery's opening hours (equal to the CCG average).

The results of the latest patient survey conducted by the practice's patient participation group (PPG) indicated that some patients would like: the surgery to be open during evenings and weekends; to see their usual GP; and to see a GP within 3 weeks. They also said they had too long a wait whilst in the surgery and did not get to see the same GP consistently. These issues were included in the action plan from the survey and were subject to on going discussion and review within the practice and at PPG meetings.

In order to improve access the practice offered pre-bookable appointments six weeks in advance. In addition they also ensured that there were sufficient on the day appointment slots, with an on-call duty doctor each day to ensure that all were seen that need to be. The clinicians offered telephone consultations for patients ensuring that they were at times convenient to the patient. Telephone advice was available throughout the day from the doctors and nurses and the practice tried to ensure that this was at times that suit fitted with patients' work commitments. The practice also sent out text message reminders of appointments to patients with a mobile phone number.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice manager/assistant practice manager were nominated to operate the complaints procedure and investigate complaints. One of the GP partners was responsible for the effective management of the procedure and for ensuring that action was taken in the light of the outcome of any investigation. We noted, however, there was no reference to any organisation with whom the complainant could pursue matters further if they were dissatisfied with the handling of their complaint, for example the Ombudsman or CCG.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. Although the complaints procedure was not readily available to patients in the waiting area, there was a suggestion box in the waiting room where patients could make suggestions or comments. There was also information about making complaints on the practice website. None of the patients we spoke with had needed to make a complaint about the practice.

We were provided with an analysis of complaints received in the last year which included a summary of the complaint, consideration of what could have been done differently, action required and whether this was achieved, and any other issues raised by the complaint, for example, lessons learned. The analysis also included reference to discussion about the complaint with relevant staff. Staff we spoke with understood the complaints procedure and confirmed that any learning from complaints was discussed with them. However, we did not see documentary evidence to confirm that lessons learned had been communicated throughout the practice, for example, at practice meetings.

We reviewed the files of two complaints received in the last year regarding an appointment cancellation due to staff sickness which had not been communicated to a patient and a letter sent in error to patient about another patient. We saw that these were dealt with in a timely manner, and the response offered an appropriate explanation and apology.

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 and objectives: to provide a high standard of medical care; through support and education to improve the health status of the practice population; by monitoring and auditing services; to have systems in place to enable the practice population to feedback and make suggestions to improve the practice performance and services; and to liaise with outside bodies to promote and maintain the healthcare of the practice population. Not all staff we spoke with were aware of this statement and it was not on display for patients. However, all staff were able to articulate the essence of the practice ethos and it was clear that patients were at the heart of the service they provided.

Governance arrangements

The practice had a comprehensive range 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. Some had been updated recently on an ad hoc basis but many had not been reviewed for a number of years and others were undated.

There was a clear leadership structure with named members of staff in lead roles. For example, there were GP leads for long-term conditions, infection control, safeguarding and information governance. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We were told that QOF data was regularly discussed at clinical team meetings and action plans were produced to maintain or improve outcomes.

The practice told us about a local peer review system they took part in to benchmark services with neighbouring GP practices. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, CCG data showed that between April 2013 and March 2104 the annual A&E attendance rate for the practice was below the CCG average for all attendances and also for non-elective admissions.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, in September 2014 the practice completed and audit of the use of an antibiotic used to treat urinary tract infections following an MHRA alert. The practice performed a search and found that over the previous 12 months they had prescribed the antibiotic to 12 patients to whom the alert was relevant. An alert was set on the practice's patient record system if they attempted to prescribe the medicine patients in this group. The practice had re-run the search and since the protocol was implemented they had not prescribed the antibiotic to any patient in this group.

The practice had arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, the document was in need of review as it had not been updated for some time. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, there were regular health and safety and fire risk assessments of the practice environment and equipment. The practice also regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, the practice used a risk stratification tool to assess potentially vulnerable patients recently discharged from hospital so that the right services were accessed and available.

The practice had an on going programme of regular governance meetings. These included weekly partners meetings; weekly reception staff meetings; monthly nurse meetings; quarterly nurse/GP review meetings; quarterly safeguarding meetings; and six monthly meetings which

Are services well-led?

Good

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

involved all staff. All of these meetings were formally minuted and, from the small sample of minutes we saw, we found that performance, quality, risks and operational issues had been discussed.

Leadership, openness and transparency

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy, disciplinary procedures, and the management of sickness, which were in place to support staff. There were also policies on equality and diversity, bullying and harassment and dignity at work.

The practice acknowledged that changes in management had caused some challenges throughout the reception/ administration team but the partners and practice managers were aware of this and were currently working on a plan to help smooth this transition. The practice manager told us of discussions that she had initiated with the reception manager and GP partners to plan the future provision of administrative and reception services. We saw the minutes of the partners' meetings which took place on 22 October and 19 November 2014, where outline plans had been discussed. The practice manager was preparing a written plan for further discussion at the next partners' meeting.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, a suggestion box and complaints received. We looked at the results of the annual patient survey which identified the three priority areas for improvements were extended opening hours, shorter waiting times and more/ longer appointments. We saw as a result of this the practice had introduced double appointments for older patients, those with learning difficulties and those whose first language was not English. The other issues were in the practice action plan and were subject to on going review by the practice.

The practice had an active patient participation group (PPG), which included representatives from a range of ethnicity and age groups. The practice was trying to encourage younger families with children and working patients to become involved and the PPG was looking at ways to facilitate this, such as appointing 'practice champions' and use of e-mail to communicate PPG business. The PPG carried out annual surveys and met quarterly. The practice manager showed us the analysis of the last patient survey, which was reviewed in partnership with the PPG. The results and actions agreed from these surveys were available on the practice website, together with the minutes of PPG meetings. A copy of the most recent minutes was also posted on the dedicated PPG noticeboard in the reception patient waiting area. The practice held an annual open evening to discuss matters that have arisen in the practice, results and action plans from the patient survey and proposed service changes. The 2014 annual PPG open evening was held in November 2014 at which there were discussions with patients about changes within the practice and within Central London CCG, changes in IT systems and care records and to roll out "patient champions" for families with young children.

The practice had gathered feedback from staff through staff meetings, appraisals and on going day to day discussions. Staff told us they would not hesitate 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.

The practice had a whistleblowing policy but not all staff we spoke with were aware of the policy. However, they knew who to go to if they wished to report 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 administrative staff records and saw that they received regular appraisals. However, it was not clear that learning and development needs were consistently linked to the appraisal process.

The practice had completed reviews of significant events and other incidents which included lessons learned. Specific meetings were held to review significant events and identify area to improve outcomes for patients. For example, the practice was informed by social services of a

Are services well-led?

Good

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

potential safeguarding issue with regards to a patient and their wound dressing. Social services and the practice held a safeguarding meeting regarding the patient and found the practice had acted appropriately and the patient's wound management was correct. However, as a result of the incident, an update on wound care management was issued to nursing staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because recruitment and training records about staff employed to carry out the regulated activities were not always accurately maintained. This was in breach of regulation 20(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.