Enderley Road Medical Centre

Quality Report

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

Ratings

Overall rating for this service	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 Enderley Road Medical Centre on 5 February 2015. 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 had several ways of identifying patients who needed additional support, and was pro-active in offering this.
- 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 learned from patient experiences, concerns and complaints to improve the quality of care.

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

Importantly, the provider must:

- Ensure all GPs are trained to Level 3 in child protection in accordance with national guidance.
- Take action to address identified shortcomings with infection prevention and control practice.
- Undertake regular health and safety risk assessments and fire evacuation drills to ensure the safety and suitability of the premises.

In addition the provider should:

- Ensure evidence of discussion of significant events and complaints and the communication of lessons learned from them is recorded in the minutes of practice meetings.
- Take steps to communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure monthly emergency lighting checks are fully documented and up to date.
- Put in place a written business continuity plan to deal with emergencies that may impact on the daily operation of the practice.
- Arrange for a spare battery for the defibrillator to be available.
- Install an emergency pull cord in the patients' toilet.
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account.
- Take further steps to address dissatisfaction raised by patients about continuity of care, access to appointments and waiting times and overcrowding whilst waiting in reception.
- Ensure the complaints leaflet available in reception is made readily accessible to patients.
- Update the complaints procedure to make it clear how patients can pursue matters further if they remain dissatisfied with the handling of their complaint.
- Ensure that the practice has a written whistleblowing policy and procedure that is accessible to staff.

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 discussion of significant events and complaints and the communication of lessons learned were not routinely recorded in the minutes of practice meetings. Not all doctors were trained to Level 3 in child protection in accordance with national requirements. The practice chaperone policy was not displayed in all consulting rooms we visited. As a result of the shortcomings identified in a recent infection control audit, the practice did not comply fully with the Department of Health's 'The Health and Social Care Act 2008: Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance'. Clinical waste containers were placed unlocked in an area with low fences next to residential properties. Criminal records checks had not been undertaken for three administrative staff. The practice had not conducted a recent health and safety risk assessment of the building and environment. The practice had appropriate medical emergency equipment in place but there was no spare battery for the defibrillator. The practice had a list of all contact numbers to call in the event of major disruption to the practice's services. However, there was no written business continuity plan to deal with emergencies that may impact on the daily operation of the practice. There was no planned schedule of fire evacuation drills and none had taken place in the last year. It was expected that testing of emergency lighting would be undertaken monthly. However, there was no record of testing since November 2014.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice scored positively in their QOF performance and used QOF to steer practice activity. Staff referred to guidance from the 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. The protocol did not make reference to the Mental Capacity Act 2005

Summary of findings

with regard to mental capacity and "best interest" assessments in relation to consent. However, we found clinical staff were aware of the Act with regard to consent. There were appropriate arrangements in place to support staff appraisal, learning and professional development. The practice promoted good health and prevention.

Are services caring?

Good

The practice is rated as good for providing caring services. 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 good degree of satisfaction with the care and treatment they received. Feedback from patients during the inspection was mostly positive about the services they received although some raised dissatisfaction with the difficulty in getting an appointment with the doctor of their choice. Patients indicated that staff were caring and treated them with dignity and respect and involved them in decisions about their care and 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. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, but acknowledged this was a challenge when set against the need to provide urgent appointments. There was an effective complaints system, although 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. However, the practice recognised that the waiting area was not big enough and building plans had been submitted which included a bigger waiting area. Decisions from the relevant authorities were awaited on the funding of this.

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

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to providing them with the best possible service. The ethos was reflected in the practice's statement of purpose. Not all staff we spoke with were aware of this statement and it was not on display for patients. However, 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. 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. A recent fire risk assessment had been completed. However, the practice had not conducted a recent health and safety risk assessment of the building and environment to help ensure patients, staff and visitors were fully protected from the risk of unsuitable or unsafe premises. In addition, there was no written business continuity plan in place to deal with major disruption to the service. The practice had an ongoing programme of 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.

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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. There were effective risk assessment processes in place. The practice was supported by a primary care navigator in the review of care planning for older patients and those with complex needs. The navigator facilitated patient access to services such as Age UK, social services and hope support (a charity supporting people when a close family member has a life-threatening illness). The practice had close links with the district nurses, palliative care team and health visitors and in multidisciplinary team meetings reviewed care planning for older and vulnerable patients. Each patient over 75 had a named GP. They also had care plans which were actively added to and amended as circumstances changed. For older patients and patients with long term conditions home visits were available if required. The practice supported four nursing homes, two of which cared for frail elderly patients. A dedicated GP was allocated to each home and they carried out weekly ward rounds. Flu vaccinations were provided to older people in at-risk groups. There were effective arrangements in place to support carers including a carer's register, a carer's passport to facilitate carers' services, an annual health check and appointments convenient to them. There were appropriate and effective end of life care 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 a range of long term conditions including diabetes, hypertension and chronic obstructive pulmonary disease (COPD) and chronic heart disease (CHD). There were recall procedures for patients on high risk anticoagulants and medicines for rheumatoid arthritis. All patients with one or more long term conditions had care plans and were proactively recalled for a review. Joint diabetic clinics were run with the community diabetic liaison nurse who assisted in the management of difficult and complex cases. The practice worked with the local community cardiac failure nurses and referred appropriate patients to the local cardiac rehabilitation clinic. The practice met regularly with the local asthma lead to update the management of vulnerable asthmatics and the local respiratory nurse for the management of severe COPD patients. COPD patients were issued with rescue packs and enrolled onto the Meteorological

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Office weather alert scheme. Flu vaccinations were offered to patients in at risk groups, including patients with long term conditions. For patients with long term conditions home visits were available and longer appointments were provided when needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided a family planning service during normal surgery times, including a coil fitting service and smear testing. Performance for cervical smear uptake was 4.3% below the CCG average. The practice ran antenatal and post natal care clinics with community midwives. There were procedures in place to safeguard children and young people from abuse. Both clinical and non-clinical staff had received child protection training, although some GPs were trained at Level 2 and not Level 3 as required under national guidelines. There was a system to highlight vulnerable patients on the practice's electronic records and the practice kept 'at risk registers' for both children and vulnerable adults. The practice had also produced a guidance leaflet on domestic violence for use by clinical staff There were fortnightly meetings with health visitors to review at risk children and families. In addition the practice held separate safeguarding meetings periodically and sometimes opportunistically to review individual cases. There was a system to ensure all children who did not attend outpatient appointments were followed up. The practice also had access to the local multi-agency safeguarding hub (MASH) being piloted in the area. Daily open access immunisation clinics were available for children. Flu vaccination was offered to pregnant women.

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, the practice provided a Tuesday evening commuter surgery from 6.30pm to 8.50pm. The practice offered a health check to all new patients registering with the practice. Optional health checks were also available for registered patients who had not been seen at the surgery for three years or more. NHS Health Checks were offered to all patients aged 40 to 75 years. 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 offered smoking cessation advice and support. Flu vaccinations were offered to patients aged 65 and older and the practice provided travel vaccinations

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(including yellow fever) and advice. Patients requiring dietary advice were referred to the onsite dietetic clinic. Patients who were obese could be referred to an obesity clinic. The practice was also proactive in promoting patient involvement in exercise through the local 'exercise on referral' programme.

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. The practice had recognised the needs of different groups in the planning of its services. For example, all GP partners were trained in substance misuse and the practice had a shared clinic with the Westminster drug project where they looked after a number of patients. The practice kept a register of all patients with a learning disability and routinely recalled them to review and check their physical health and well-being. They were supported to make decisions through the use of care plans, which they were involved in agreeing. There was also a register for carers and carers' details were flagged in patient records. The practice supported four local nursing homes including one where many young high dependency disabled patients live. Staff had been trained in safeguarding of vulnerable adults knew how to recognise signs of abuse and the process to follow in the event of any safeguarding concerns. 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 meet the needs of patient with disabilities. The practice was accessible for wheelchair users, although the reception desk was too high for them to use independently. Accessible toilet facilities were available for all patients. However, there was no emergency pull cord provided in the disabled toilet. Building plans had been drawn up including improved disabled access for which funding was being sought.

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 monitored repeat prescribing for people receiving medicines for mental ill-health including high risk drugs and undertook reviews when repeat limits were reached. Clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. However, the practice's consent protocol did not make reference to the Act with regard to mental capacity and "best interest" assessments in relation to consent. Staff responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Crisis referrals were made for acute mental health issues and the practice was able to facilitate same-day access to

psychiatric support. If a patient with a mental health problem did not attend appointments for hospital referrals on three consecutive occasions, the practice followed this up with the patient. The practice took over the care of stabilised patients with mental health problems from secondary care providers. They liaised closely with secondary care on high risk patients by phone and secure email. Patients with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The practice also screened all at risk patients for dementia and there were regular reviews of patients with dementia and auditing of the use of antipsychotic medicine for this group.

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What people who use the service say

We received four completed Care Quality Commission (CQC) comments cards providing feedback about the service. On the day of our inspection we also spoke with 12 patients, including two representatives of the practice's patient participation group (PPG). The majority of patients we spoke with were positive about the service experienced. They told us told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. All but one felt that health issues were discussed sufficiently with them and they were involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff but one patient commented that consultations felt rushed because the doctors were so busy. Two patients who completed CQC comments cards commented positively about the service and felt staff were patient, caring and professional. Two felt the practice had lost its family orientated approach. All four commented on the difficulty in getting an appointment with the doctor of their choice, although one said it was worth the wait.

In the national patient survey 2013/14 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. Scores were less favourable for access to appointments. Eighty-four percent of respondents said they were able to get an appointment to see or speak to someone the last time they tried. Eighty-three percent said their last appointment was convenient but only 63% described their experience of making an appointment as good.

Sixty-five percent of respondents said they usually wait up to 15 minutes after their appointment time to be seen, which was 7% higher than the CCG average. Seventy-five percent were satisfied with the surgery's opening hours but only 39% said they don't normally have to wait too long to be seen.

We also looked at the patient survey of 115 patients conducted through the PPG for 2013/2014. The PPG survey asked different questions to the national survey. Aspects of the service identified by respondents as particularly good included doctors and reception staff being very helpful. The action plan agreed with the PPG in response to the survey included the advancement of plans for premises improvement, including improved disabled access, and the continuing monitoring of the appointment system.

The two PPG members we spoke with, including the chair, told us that the group had an excellent working relationship with the practice and they welcomed improvements such as doctors calling patients back on the same day to provide telephone advice, and being able to obtain early morning blood tests. They highlighted the difficulties of doctors managing the increasing size of the patient list which impacted on the service for all patients; continuity of care; and the continuing problem of patients being able to get appointments. They acknowledged the practice was committed to making improvements but felt there was not a clear solution to these issues, particularly the difficulties with appointments.

Areas for improvement

Action the service MUST take to improve

- Ensure all GPs are trained to Level 3 in child protection in accordance with national guidance.
- Take action to address identified shortcomings with infection prevention and control practice.
- Undertake regular health and safety risk assessments and fire evacuation drills to ensure the safety and suitability of the premises.

Action the service SHOULD take to improve

- Ensure discussion of significant events and complaints and the communication of lessons learned from them is recorded in the minutes of practice meetings.
- Take steps to communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure monthly emergency lighting checks are fully documented and up to date.

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- Put in place a written business continuity plan to deal with emergencies that may impact on the daily operation of the practice.
- Arrange for a spare battery for the defibrillator to be available.
- Install an emergency pull cord in the patients' toilet.
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account.
- Take further steps to address dissatisfaction raised by patients about continuity of care, access to appointments and waiting times and overcrowding whilst waiting in reception.
- Ensure the complaints leaflet available in reception is made readily accessible to patients.
- Update the complaints procedure to make it clear how patients can pursue matters further if they remain dissatisfied with the handling of their complaint.
- Ensure that the practice has a written whistleblowing policy that is accessible to staff.

Outstanding practice

The practice participated in a national work experience apprenticeship scheme. Through the scheme, two members of the administrative staff had been provided with work experience at the practice which led to permanent jobs within the administrative team. The practice had been awarded 'Work Experience Employer of the year 2013' by Skills Training UK in recognition of their successful participation in the scheme.

Enderley Road Medical Centre

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 Enderley Road Medical Centre

Enderley Road Medical Centre provides primary medical services through a Personal Medical Services (PMS) contract to around 13,500 patients in Harrow Weald, Middlesex (North West London). The practice area incorporates Harrow Weald predominantly with parts of Wealdstone and Stanmore. The Practice has a highly ethnically diverse patient population. The practice has high proportions of patients originating from India, Pakistan and Sri Lanka. It also has many patients from Somalia, Afghanistan, Iran, Iraq as well as eastern European countries such as Poland and Romania. Many patients are elderly having lived in Harrow Weald all their lives. Some of the practice population is living in areas of deprivation particularly in Wealdstone, but there is a mix of the self-employed, commuters and professionals in more affluent areas of Harrow Weald.

The practice provides services from a single location and is registered to carry on the following regulated activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Surgical procedures; and Treatment of disease, disorder or injury; the practice has extended the site on four occasions to form the current premises. Another extension is proposed to meet an expanding patient population and improve facilities for disabled patients. The practice has submitted plans to the local planning department and applied for funding.

The practice team is made up of a team of GPs (eight female and three male) The practice employs a practice manager, assistant practice manager, an IT manager, three data room/IT staff, three practice nurses, two health care assistants, a phlebotomist, plus reception and administrative staff.

The practice is a teaching practice having two GP trainees, one or two F2 doctors (in the second year of their foundation programme) and undergraduate students.

Appointments are available from 8:00am to 6.30pm on weekdays. The practice also provides a Tuesday evening commuter surgery from 6.30pm to 8.50pm.

The practice introduced a new appointment system in November 2014 which included a new telephone system, dedicated phone advice from a GP with a call back within one working day, online booking and online prescriptions and the employment of a new receptionist to increase resources answering phones.

Out of hours services are provided by a local provider. Access to the service is via the national NHS 111 call line. The NHS 111 team will assess the patient's condition over

the phone and if it is clinically appropriate, will refer the case to the out of hours service. Patients are advised of the out of hours service on the practice's website and in the practice booklet.

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 NHS Harrow Clinical Commissioning Group (CCG), Healthwatch Harrow and NHS England.

We carried out an announced visit on 5 February 2015. During our visit we spoke with a range of staff including four GPs and an F2 doctor, a nurse and health care assistant, the practice manager, reception supervisor, practice secretary, IT manager, data clerk, and two reception/administrative staff. We also spoke with 12 patients who used the service, including two 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 comment cards where patients shared their views and experiences of the service.

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. For example, a patient raised concerned over conflicting information given following a blood test and a delay in obtaining a referral letter. This was reviewed by a GP and an explanation offered to clarify the test outcome. An apology was offered for the delay in receiving the referral letter and action was taken in the practice to communicate the outcome of the incident to ensure in the future, there was no delay in processing referrals.

Learning and improvement from safety incidents

The practice kept records of significant events and a summary was made available to us before the inspection for events that had occurred during the last year. These records provided a description of the issues that impacted on the patient, defined area for improvement and action taken. Staff we spoke with told us the outcomes of significant events were discussed with them. We were told also that any significant events would be discussed at practice meetings and lessons learned communicated. However, we did not see evidence of this in the minutes of meetings we looked at and such events were not a permanent item on the agenda of the practice meetings. The practice manager has since shared with us the measures put in place immediately after the inspection in response to these findings. Significant events had been added as a fixed agenda item on the practice's two weekly practice and staff meetings in order that actions taken may be confirmed, followed up and recorded in the minutes.

Staff used incident forms on the practice computer system and sent completed forms to the practice manager. We saw records were completed in a comprehensive and timely manner and included suggestions to prevent recurrence and specific action required. For example, in one patient's case shortfalls were found in the notification and referral processes to social services and ante natal care. It was recognised that the notification should have been made by both phone and the relevant notification form. Appropriate coding of the patient should also have taken place to identify the patient as vulnerable. The issue was discussed with the practice's GP safeguarding lead and information shared with other agencies appropriately. Referrals to antenatal care were followed up with a phone call to ensure receipt. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

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 distributed any alerts and guidelines to staff within the practice by email. All GP staff received NICE guidance direct and decided collectively at practice meetings how to act on the guidance. For example, NICE guidance on hypertension management was reviewed within the practice and then uploaded on to the practice computer to ensure standardised care of patients newly diagnosed with the condition. We saw also summaries the practice had produced for the practice team of updated guidelines in the primary and secondary prevention of cardiovascular disease (CVD) and chronic kidney disease (CKD).

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. We were shown certificates for training in safeguarding both children and vulnerable adults which staff had undergone. These showed that all but three GP staff had received child protection training at Level 3, nurses at Level 2 and administrative staff at Level 1. Three GPs were trained at Level 2, including one on maternity leave at the time of the inspection. In order to be compliant with current regulations, doctors should be trained to Level 3 in child protection. However, the practice had arrangements in hand to address this.

There was a system to highlight vulnerable patients on the practice's electronic records and the practice kept 'at risk registers' for both children and vulnerable adults, which we saw. This included information to make staff aware of any

relevant issues when patients attended appointments; for example children subject to child protection plans. The practice had also produced a guidance leaflet on domestic violence for use by clinical staff. There were fortnightly meetings with health visitors to review at risk children and families. In addition the practice held separate safeguarding meetings periodically and sometimes opportunistically to review individual cases. We saw for example that a child who had attended A&E with a fracture was called in for an appointment and was reviewed by the GP safeguarding lead. There was a system to ensure all children who did not attend outpatient appointments were followed up. The practice also had access to the local multi-agency safeguarding hub (MASH) being piloted in the area. The MASH brought together all key professionals in one place, to deal with child protection and sat alongside the local authority Children's Access Team. All clinical staff provided child protection reports and information in response to requests from social services and we saw these were provided in timely manner.

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. We saw certificates showing that clinical staff who acted as chaperones had undertaken formal chaperone training at the practice. Administrative staff who occasionally acted as a chaperone had not undertaken such training. However, those staff we spoke with had received briefing about the role at the practice and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had recently audited the recording on patient records of the use of chaperones in accordance with the chaperone policy. This was a repeat of an audit carried out in 2011. The audit found recording had improved since the first audit. Additional actions arising included discussion of the results at a practice clinical meeting, the creation of additional 'read codes' for the offer or refusal of a chaperone and updating the induction programme for new doctors to include more on chaperoning.

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy as evidenced by the storage practices we observed and the records we reviewed which showed temperatures were maintained within the required range.

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.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. 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. The issue of prescriptions for anticoagulants and specific mental health medicine was dependent upon appropriate blood tests taking place. We saw evidence that the tests had taken place.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and under the practice's prescription security profile were kept securely at all times.

No controlled drugs were kept at the practice. Expired and unwanted medicines were disposed of in line with clinical waste regulations.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice was cleaned daily but there was no written

cleaning schedule in place. We noted that the need for a cleaning schedule had been identified in a recent infection control audit and was in the action plan for implementation.

The practice had a lead for infection control who provided ongoing advice to staff on practice infection issues. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that infection control audits were carried out and minutes of practice meetings showed that the findings of the audits were discussed.

We noted the infection control audit carried out in January 2015 had made several recommendations and remedial actions to resolve problems identified. The problems included a lack of all relevant infection control policies; no evidence that the practice had undertaken a risk assessment for Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) or had a written policy for prevention of Legionella contamination; there was carpet flooring in clinical treatment rooms; and sinks did not comply with Department of Health requirements. The practice was in the process of implementing the audit recommendations. However, as a result of these shortcomings, at the time of our inspection the practice did not comply fully with the Department of Health's 'The Health and Social Care Act 2008: Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance'.

There was appropriate personal protective equipment available to staff including disposable gloves, aprons and coverings. Staff we spoke with were able to describe how they would use these to prevent the spread of infection. There was a process for internally recording and reporting untoward incidents in relation to infection prevention and control (including sharps injuries and body fluid splashes). Staff knew the procedure to follow in the event of such incidents.

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.

Clinical waste was stored in appropriate containers and a contract was in place for its collection and disposal. However, we noted that the waste containers located in an area next to residential properties, with low fences were not locked. The practice informed us immediately after the inspection that locks had been ordered from the waste contractor.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment was routinely tested and we saw evidence of calibration of relevant equipment dated February 2014; for example weighing scales, spirometers, blood pressure measuring devices, thermometers and the vaccine fridges.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). 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. The practice policy was to undertake DBS checks on all staff working at the practice regardless of role. At the time of the inspection there were checks outstanding for three administrative staff but arrangements were in hand for these to be completed.

We were told that all staff received a comprehensive induction as part of the recruitment process. Staff we spoke with confirmed that they had followed an induction process and been provided with a clear job description which had been effective in helping them take on their new role. The F2 doctor (in the second year of their foundation programme) we spoke with felt they received effective developmental support and supervision.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. 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 an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We saw that there was a good skill mix of GP staff with interests covering dermatology; minor surgery; paediatrics; gynaecology; contraception; acupuncture; gastroenterology; musculoskeletal medicine and diabetes. We discussed with the practice the number of nursing staff (3.07 full time equivalent) in relation to the relatively large and growing patient list. The practice considered the nursing resources were sufficient to meet the current nursing demands, particularly now that the phlebotomist also supported the nursing team for two sessions per week as a healthcare assistant (HCA). The practice also received additional nursing support through a nursing direct enhanced service scheme. A lead practice nurse from the scheme attended fortnightly practice meetings and the practice was able to readily obtain advice from the nurse when needed. The practice acknowledged that nursing resources were at the upper limit and if the patient list continued to grow they would need to review staffing levels.

We were told of a work experience apprenticeship scheme the practice participated in. Two members of the administrative staff were provided with work experience at the practice which led to permanent jobs within the administrative team. We saw that the practice had been awarded 'Work Experience Employer of the year 2013' by Skills Training UK in recognition of their successful participation in the scheme.

Monitoring safety and responding to risk

The practice had a health and safety policy. Health and safety information was displayed for staff and patients to see. The practice carried out visual inspections of the premises and equipment on a daily basis. However, these checks were not routinely documented and the practice had not conducted a recent health and safety risk assessment of the building and environment to ensure patients, staff and visitors were fully protected from the risk of unsuitable or unsafe premises.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Crisis referrals were made for acute mental health issues and the practice was able to facilitate same-day access to psychiatric support.

There were arrangements to monitor high risk groups. For example, if a patient with a mental health problem did not attend appointments for hospital referrals on three consecutive occasions, the practice followed this up with the patient. Similarly, if children did not attend for appointments, the practice contacted the parent or guardian to find out the reason why.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all but three recently recruited administrative staff had received training in basic life support. The practice had arrangements in hand for them to attend appropriate training. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff, confirmed that this equipment was checked regularly. We saw the equipment was operational, although there was no spare battery for the defibrillator.

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 in place to check medicines were within their expiry date and suitable for use. However, when we checked the emergency medicines kit we found some medicine had gone beyond the expiry date. The practice looked into this immediately and found that the out of date medicine had been replaced but in error had not been removed from the emergency bag. As a result the practice initiated an immediate change in procedure so that when carrying out monthly checks on the emergency medicines a second nurse doubled checked the medicines to stop the possibility of this happening again. The practice assured us further that doctors would also check the batch number and expiry date prior to administering medicines. Expired and unwanted medicines were disposed of in line with waste regulations.

Requires improvement

Are services safe?

The practice had a list of all contact numbers to call in the event of major disruption to the practice's services. However, there was no written business continuity plan in place to deal with emergencies that may impact on the daily operation of the practice.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. We were shown the action plan for this and told that most of the action had been implemented. The action plan had not been completed showing this but this was updated during the inspection. Staff received appropriate fire safety instruction and training. However, there was no planned schedule of fire evacuation drills and none had taken place recently. The practice ensured, though, that staff were aware of the assembly point outside of the building in the event of an evacuation. There was monthly fire alarm testing and we saw the records for this. It was expected that testing of emergency lighting would also be undertaken monthly. However, there was no record of this since November 2014.

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. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told that new guidelines and alerts were disseminated by email and discussed at weekly clinical practice meetings, including the implications for the practice's performance and the action required for individual patients. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We saw from minutes, for example, that new Ebola guidance was discussed at a practice meeting in and action agreed to disseminate within the practice protocols on how to deal with suspected Ebola incidents.

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. For example, following new NICE guidelines on non-vitamin K antagonist oral anticoagulants (NOACs) used to reduce the risk of stroke, the practice carried out an audit of patients prescribed anticoagulants and subsequently contacted them to review their medicine and initiate management of NOACs. GPs also told us about assessment protocols they used and we saw the new protocol for hypertension management which had been made available on the practice computer system so that trainee GPs and locums could also use it.

The GPs told us they led in specialist clinical areas such as medicines management, paediatrics and gynaecology and the practice nurses supported this work. 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. To facilitate this, the practice held fortnightly educational meetings tailored to the learning and development needs of staff where clinical knowledge was shared. Clinical consultants were invited to these meetings to impart their expertise in specific areas. We saw the minutes of a meeting where cancer care was discussed and action and learning points identified.

There were care plans in place for patients with complex needs including long term conditions and we saw the practice register for this which recorded the date of multidisciplinary team meetings, review dates (usually annual but depending on need) and the reason for review. Care plans were also in place for hospital admission avoidance under a direct enhanced service (DES) scheme for unscheduled admissions. We saw the doctors' guide for this which set out the processes to follow in setting up care plans and when discharge summaries were received of patients on the admission avoidance register.

The practice used national standards for patient referrals. These included, for elective referrals, low priority treatment pathways for a range of conditions via the local planned procedures with threshold (PPWT) system and for urgent cases, for example for patients with suspected cancers, two week referrals. All referrals to secondary care were reviewed by another doctor to ensure they were clinically sound. The practice also held periodic referral review meetings.

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. For example, we were told of a discussion within the practice about treatment decisions based on religious grounds and the management of this to ensure patients' needs were properly met.

Management, monitoring and improving outcomes for people

The practice showed us six clinical audits that had been undertaken Two of these were completed audit cycles where the practice was able to demonstrate improvement since the initial audit. For example, we reviewed a repeat audit of the prescribing of Vitamin D to patients with multiple sclerosis (MS). Vitamin D is thought to play an important role in the treatment of the disease, for example, in reducing the number of predicted relapses when prescribed a particular dosage. In the first audit in December 2012 only 7 of 36 patients were prescribed Vitamin D and none at the dosage thought to be beneficial.

Good

Are services effective?

(for example, treatment is effective)

In the second audit in January 2015, after follow up and review with patients 29 of the 32 were now prescribed the recommended dose. The practice wrote to the other three advising that they start the daily recommended dose. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antipsychotic medicine to patients with dementia. Following the audit, the GPs carried out medication reviews for each patient prescribed these medicines and made a referral to a psychiatrist to ensure that the use of the their medicine was appropriate. GPs maintained records showing they had documented the success of any changes.

Some doctors in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used that in their learning. We saw an example of an audit completed in October 2013 which recorded a correlation rate of 62.5% with suspected diagnosis and confirmed histological diagnosis.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2013/14 the practice performed above the CCG average for a number of indicators. For example, 4.1 percentage points patients with asthma, 7.2 percentage points for chronic obstructive pulmonary disease (COPD), 8.4 percentage points for diabetes and 7.5 percentage points for chronic heart disease (CHD). Cervical screening was 4.3 percentage points below the CCG average but the practice explained this as partly due to the rapid turnover of patients. The practice was taking action to secure improvement in this and other areas using a computer based tool to analyse data and help focus effort where it was best placed, taking account of the practice size and the latest national and practice disease prevalence figures.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines, including a prescription security protocol. Repeat prescriptions could be ordered on-line, by fax, by post, by email or in person at the practice. Patients were asked to allow three working days for repeat prescriptions to be processed before collection, making allowance for weekends and public holidays. There were also arrangements with local pharmacies that collected prescriptions from the practice on a daily basis. Patients with repeat prescriptions were asked to see the doctor for a medication review at regular intervals to decide whether they should continue their medication. There was an alert on the practice's computer to identify when a review was due. Working with pharmacists the practice audited patients having 10 repeat prescriptions or more. Blister packs were organised for patients who needed support in managing the medicines.

The practice participated in local benchmarking run by the CCG through local and direct enhanced schemes (LES and DES) and local improvement schemes (LIS). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. These included LES for A&E referrals, learning disability, a DES for dementia and LIS for mental health and safeguarding. The practice also collaborated with its local 'Cluster' of GP practices looking at prescribing, ICP (integrated care plans) and trying to reduce referrals.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that in the majority of cases staff were up to date with attending mandatory courses. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had or had requested 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).

Good

Are services effective?

(for example, treatment is effective)

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, cervical cytology, spirometry, family planning and diabetes treatment.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. We saw on staff records that appraisal reports had been completed and staff we spoke with confirmed they had received an appraisal. This included the opportunity to discuss and agree their personal learning and development needs. Staff told us they found the appraisal process helpful and felt the practice was good at supporting training and allowing time to attend courses when needed. The practice manager told us appraisals for the current reporting year had been delayed but were expected to be completed by March 2015. We saw that invitations had been issued to staff to complete the self- appraisal form which initiated the process.

Administrative staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to and there were regular opportunities to discuss work matters at monthly practice meetings. We saw a sample of minutes of these meetings. We saw for example from meeting minutes that new staff recruitment, training, occupational health, equipment and IT issues were reviewed at a meeting in January 2015.

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 service

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 held regular multidisciplinary team meetings attended by health visitors, district nurses, social workers palliative care nurses to make decisions about care planning. We saw from notes of these meetings that there were good records of issues discussed and action plans documented in shared care plans. The practice was also supported by a CCG based primary care navigator who visited weekly to review care planning for older patients and those with complex needs. The navigator facilitated patient access to services such as Age UK, social services and hope support (a charity supporting people when a close family member has a life-threatening illness).

Where appropriate, the practice referred patients to the local Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) which provided a multi-disciplinary, holistic assessment of patients in their own home or in A&E, within two hours of referral. The service was for patients who were in urgent need of care and at risk of admission into hospital. It also facilitated early discharge for patients in hospital by providing hospital-at-home services in the community and short-term rehabilitation - providing neurological and general rehabilitation at home and a falls service. GPs liaised closely with the service at each stage.

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 and the majority were seen by a GP on the same day and urgent cases actioned. Results were usually received electronically and paper copies given to each doctor personally. Arrangements were in place to ensure action was taken when GPs were absent. Patients with abnormal blood results were called in for an appointment by the GP in urgent cases. Patients were advised that results would take about a week and to call between 1.30 and 4.00pm where a message would be left for them by their doctor.

Out of hours services were provided by a local provider. Access to the service is via the national NHS 111 call line. The NHS 111 team will assess the patient's condition over the phone and if it is clinically appropriate, will refer the case to the out of hours service. Patients were advised of the out of hours service on the practice's website and in the practice booklet.

The practice supported four local nursing homes including one where many young high dependency disabled patients live, a specialised home for the elderly mentally ill, and two homes which care for typically frail elderly patients. A dedicated GP was allocated to each home and they carried out weekly ward rounds.

The practice provided effective end of life palliative care. The practice worked closely with others to support patients

Good

Are services effective?

(for example, treatment is effective)

receiving palliative care. There were multidisciplinary meetings with the palliative care team to review patients on the practice's end of life care register and update information about them.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, electronic systems were in place for making referrals, the majority of which were made through 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). We saw evidence of referrals made. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. 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 systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice would be moving to a new CCG–wide system in April 2015 and had plans in place to manage the transition.

Consent to care and treatment

The practice had a consent protocol which was understood and applied by staff. They confirmed they would always seek consent before giving any treatment and would make entries in patient records about consent decisions where appropriate. We saw that consent forms were available for use by clinical staff, for example for minor surgery, birth control implants and the fitting of coils and we saw evidence of completed forms. The protocol did not make reference to the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. However, we found clinical staff were aware of the Act with regard to consent. Patients had access to an independent advocacy service provided by the local council.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. We saw an example of a multidisciplinary best interest discussion for a patient receiving palliative care who lacked capacity to make decisions about advance care planning. This also recorded agreement to a previous 'do not attempt resuscitation' (DNACPR) decision.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

There were health promotion leaflets available to patients in the waiting area, although this was limited and did not include for example signposting to bereavement or community services. However, there were a wide range of leaflets on the practice's computer system, which clinical staff could print off for patients during appointments. There was also relevant health promotion information on the electronic screen in reception and on the practice website. The website included links to the NHS Choices Website, and a comprehensive range of health conditions, answers on common health problems and advice on 'living well'. The practice's patient association newsletter was also available via the website and contained a range of health promotion information.

It was practice policy to offer a health check to all new adult patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. One patient we spoke with told us they had been offered an appointment with an asthma nurse after completing the registration form, which they thought was a positive, proactive step.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 376 patients in this age group (5.25%) took up the offer of the health check in the last year, compared to 6% for the CCG area. We saw the information provided to patients on the outcome of the check which included goal setting in relation to any risk issues identified. We also saw from

Good

Are services effective?

(for example, treatment is effective)

patients' records that they were involved in decisions about life choices on health and wellbeing. Optional health checks were also available for registered patients who had not been seen at the surgery for three years or more.

The practice had several ways of identifying patients who needed additional support, and it was pro-active in offering this. For example, the practice kept a register of all patients with a learning disability and those receiving palliative care. Practice records showed 30 out of 36 (83%) patients with a learning disability offered one had received an annual health check in the last 12 months. The practice also screened all at risk patients for dementia and there were regular reviews of patients with dementia and auditing of the use of antipsychotic medicine for this group.

There was also a register for carers and carers' details were flagged in patient records. The practice had a carers identification protocol which set out arrangements in place to enable the practice to support carers and ensure they were referred appropriately to social services for a carers assessment. Each carer on the register was provided with a carer's passport which they could present at reception or quote the serial number to facilitate carers' services. Carers were also offered an annual health check and appointments convenient to them. Information about carer support was also available on the practice's website.

There were also mechanisms in place to support health and wellbeing of particular patient groups in line with their needs. The practice identified the smoking status of patients over the age of 16 and provided on site access to a clinical psychologist for smoking cessation advice. Patients requiring dietary advice were referred to the onsite dietetic clinic. One patient we spoke with who had diabetes told us they attended the practice's diabetic clinic and a dietician from a local hospital present at the clinic had offered them advice and signed them up for dietary group sessions. Patients who were obese could be referred to an obesity clinic. The practice was also proactive in promoting patient involvement in exercise through the local 'exercise on referral' programme.

There was an automated blood pressure machine at the practice which patients could access for self- checks. The practice also provided ambulatory monitoring (when your blood pressure is being measured as you move around, living your normal daily life, normally carried over 24 hours) and home monitoring.

The practice provided a family planning service including fitting/removal of coils and smear testing. All pregnant women were offered a new pregnancy pack. Opportunistic screening for sexually transmitted diseases (STDs) was carried out during appointments and in-house pregnancy testing was provided if medically needed. The practice also undertook glucose tolerance tests for pregnant women to diagnose diabetes in pregnancy (gestational diabetes).

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 a 67% uptake of flu vaccination offered to patients aged 65 and older, which was below the national average of 73%. The practice followed up patients who did not attend if they were known to be in high risk groups.

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 115 patients undertaken by the practice's patient participation group (PPG). The evidence from these sources showed patients were satisfied with how they were treated by the staff and that this was with compassion, dignity and respect. For example, in the national patient survey 91% of respondents rated the last GP they saw or spoke to as good at treating them with care and concern. This rating was 10 percentage points above the CCG average. The practice was also above average for its satisfaction scores on consultations with doctors with 90% of practice respondents saying the GP was good at listening to them and 89% saying the GP gave them enough time. This was also reflected in the PPG survey

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and the views were mixed about the service experienced. Two patients commented positively about the service and felt staff were patient, caring and professional. Two felt the practice had lost its family orientated approach. All four commented on the difficulty in getting an appointment with the doctor of their choice, although one said it was worth the wait. We also spoke with 12 patients on the day of our inspection, including two 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. However, the curtain in the nurse's room we visited offered limited privacy. 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. 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 and was stated in the practice booklet made available to patients.

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 favourably in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions, which was 6% above the CCG average. In addition 90% felt the nurse was good at explaining treatment and results, 8% above the CCG average.

All but one of the 12 patients we spoke with on the day of our inspection felt that health issues were discussed sufficiently with them and they were involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff but one patient commented that consultations felt rushed because the doctors were so busy.

Staff told us that the majority of patients were able to communicate readily with them. But translation services were available for patients who did not have English as a first language. We saw also that the practice's website had a translation facility for each page in a wide choice of languages. In addition some of the staff spoke other languages, for example Romanian and Polish.

We saw evidence of care plans in place for older patients, patients with long term conditions, patients with learning disabilities and patients with dementia. We also saw appropriate information about end of life care planning for patients receiving palliative care.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, in the national patient survey 2013/14, 94% of respondents had confidence and trust in the last GP they saw or spoke to and 98% had confidence and trust in the last nurse they saw or spoke to. One patient we spoke with told us when they were very ill in hospital the follow up support they received from their doctor was very good. We saw too on the NHS Choices website a favourable comment on the practice's rapid and reassuring response to a very unwell patient and the arrangement of local support services which had facilitated their recovery.

During consultations the practice provided patients with information on 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 primary care navigator attached to the practice facilitated patient access to services such as Age UK, social services and hope support (a charity supporting people when a close family member has a life-threatening illness) for those in need of such services.

The practice appropriately supported patients receiving end of life care. The doctors and nurses worked closely with the palliative care team and district nurses to ensure palliative medicines were available when needed. We saw the template on the practice's computer system, used for each patient to ensure correct doses and quantities were provided for PRN (taken as needed) medicines and those administered by a syringe driver.

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' healthcare needs and had systems in place to maintain the level of service provided. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided.

The practice engaged regularly with the local Clinical Commissioning Group (CCG) and other practices at locality meetings to discuss local needs and service improvements that needed to be prioritised. For example, the practice was collaborating with a local practice to consider how to provide an 8am to 8pm service Monday-Friday and a weekend service. The practice attended a monthly implementation coordination group to plan and review developments in this respect. One of the GP partners was a CCG lead paediatric GP involved in the development of children's policies in Harrow.

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). These included a dedicated phone advice GP with call back within one working day; a new phone system; online booking and online prescriptions; and the employment of new reception staff to increase staff resources answering phones.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, but acknowledged this was a challenge when set against the need to provide urgent appointments. They felt that the situation had improved over the past two years and reliance on locum doctors had reduced with the appointment of new associate doctors. No locums were employed at the time of the inspection. In the national patient survey 2013/14 the practice scored 38% for patients with a preferred GP who usually get to see or speak to that GP. This was 13% below the CCG average. The practice had three male and eight female GPs, so was able to offer choice of male or female doctor if this was requested.

Each patient over 75 had a named GP. They also had care plans which were reviewed regularly at multidisciplinary team meetings and added to and amended as circumstances changed. Each patient was sent a copy of their care plan. They had access to a bypass number for the practice so they could readily access home visits and appointments. Home visits were available for older patients, patients with long term or chronic conditions and patients receiving palliative care. The practice nurse made visits to those with chronic conditions and doctors offered patients with complex medical needs proactive visits to review medicine and optimise care. The practice met regularly with district nurses to review their nursing care. Housebound patients were offered flu vaccinations.

The practice ran antenatal and post natal care clinics with community midwives and fortnightly child health development and surveillance clinics with health visitors. The notes of pregnant women who self-referred for ante natal care were reviewed to ensure there were no pertinent medical or safeguarding issues the obstetric team should be made aware of. Family planning was also provided in normal surgery times. Open access immunisation clinics were available for children.

There were clinics for minor surgery, laser and cryotherapy treatment, diabetic checks, blood pressure checks (by pre-booked appointment or self-check by patient), phlebotomy, asthma and COPD management (including spirometry for diagnosis), anti-coagulant control and monitoring; and travel advice and vaccination (including yellow fever). Services provided by the practice also included in-house physiotherapy, appointments with a dietician, chiropody, acupuncture, dermatology and joint injections.

Joint diabetic clinics were run with the community diabetic liaison nurse who assisted in the management of difficult and complex cases. The needs of new diagnosed patients were reviewed and referred to appropriate education programmes, a dietician and eye screening. Practice nurses had all completed a recognised course in diabetes care.

The practice met regularly with the local asthma lead to update the management of vulnerable asthmatics and the local respiratory nurse for the management of severe COPD patients. The local Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) was used for the home management of patients requiring short periods of home nebulisation and monitoring. COPD patients were issued with rescue packs and enrolled onto the Meteorological Office weather alert scheme.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice worked with the local community cardiac failure nurses and referred appropriate patients to the local cardiac rehabilitation clinic.

The practice took over the care of stabilised patients with mental health problems from secondary care providers. They liaised closely with secondary care on high risk patients by phone and secure email and used a specifically designed template referral form to ensure swift and appropriate action.

The practice participated in several enhanced services schemes including those for patients with learning disabilities, child immunisations, NHS Health checks, alcohol, counselling, reducing avoidable unplanned admissions and patient participation.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, all GP partners were trained in substance misuse and the practice had a shared clinic with the Westminster drug project where they looked after a number of patients.

The practice had access to online and telephone translation services and a staff who spoke other languages such as Romanian and Polish.

The practice had an equal opportunities policy. Staff were made aware of the policy as part of the induction process and staff we spoke with understood patients' equality and diversity needs covering a diverse population of patients. We noted that specific equality and diversity training was available through e-learning and staff were now beginning to complete the on-line training package.

The premises and services had been adapted to meet the needs of patient with disabilities. The main entrance had a ramp and automatic doors for easy access. The practice was situated on the ground and first floors of the building with services for patients on both floors. There was no lift access to the first floor and if patients were not able to use the stairs, they were seen in a consulting room on the ground floor.

The practice was accessible for wheelchair users, although the reception desk was too high for them to use independently. If access proved difficult to any disabled patients and they needed to be seen on the ground floor or required further assistance they were advised to ask a receptionist. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. However, there was no emergency pull cord provided in the disabled toilet.

The practice recognised that disabled access could be improved. Building plans for which funding was being sought included more consulting rooms on ground floor, a bigger waiting room and easier disabled access.

Access to the service

Appointments were available from 8:00am to 6.30pm on weekdays. The practice also provided a Tuesday evening commuter surgery from 6.30pm to 8.50pm. The doctors ran this clinic in rotation with support from a nurse, with a Health Care Assistant also in attendance on alternate weeks. These clinics are pre-bookable appointments only. In addition the practice provided 7.30am phlebotomy appointments to suit in particular patients who worked.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours services were provided by a local provider. Access to the service is via the national NHS 111 call line. The NHS 111 team will assess the patient's condition over the phone and if it is clinically appropriate, will refer the case to the out of hours service. Patients were advised that clear instructions would be given on the practice's answerphone for patients requiring urgent medical attention and they may be referred to NHS 111 who would give advice and the appropriate action to take.

A duty doctor was on call daily to deal with emergencies which otherwise could not wait until the next day. These appointments were booked on the day but once the practice reached its capacity, patients might be asked to go to a choice of two local walk-in clinics. The duty doctor also dealt with all urgent telephone enquiries. If patients felt that their problem could not be solved by talking to a doctor, they were advised to let the receptionist know and they would arrange for a doctor to call them back. If they needed to speak to a specific doctor, they were advised that they may not receive a call back on the same day but their call would be returned within two working days.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Home visits were made to four local care homes on a specific day each week, by a named GP and to those patients who needed one.

The practice ran daily open access flu vaccination and child immunisation clinics. There was also an open access policy for children and for patients with mental health problems who needed to be seen on the same day.

The majority of patients we spoke with and received comments cards from raised issues about the appointments system. Some said it was hard to get through to the practice on the phone to make an appointment and experienced long delays with this. Others mentioned it was difficult to see the doctor of their choice but said they could see another doctor if this was not possible. Comments received from patients showed that patients in urgent need of treatment were usually able to make appointments on the same day of contacting the practice. However, others told us on occasion they were advised to visit local walk-in centres to get an urgent appointment.

Several patients we spoke with felt the waiting room was too busy and they had to wait too long for their appointment. One had been waiting for 40 minutes and another over an hour. From our own observations on the day of the inspection the reception was overcrowded particularly in the morning. Several patients were unable to sit down as all the chairs were occupied and at one stage patients were queuing outside the entrance door. The practice recognised that the waiting area was not big enough and this had been made worse as the patient list had continued to grow. Building plans had been submitted which included a bigger waiting area but decisions from the relevant authorities were awaited on the funding of this.

Data from the 2013/14 national GP patient survey showed 84% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. Eighty three percent said their last appointment was convenient but only 63% described their experience of making an appointment as good.

Sixty three percent found it easy to get through to the surgery by phone (4% below the CCG average).

Sixty five percent of respondents said they usually wait up to 15 minutes after their appointment time to be seen, which was 7% higher than the CCG average. Seventy five percent were satisfied with the surgery's opening hours but only 39% said they don't normally have to wait too long to be seen.

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 complaints procedure did not explain how patients could pursue matters further if they were dissatisfied with the handling of their complaint. However, contact details were provided for the Parliamentary and Health Service Ombudsman (PHSO) in the practice's complaints leaflet.

We saw that information was available to help patients understand the complaints system. There was a complaints leaflet available in reception, although this was not readily accessible to patients. There was also information about making complaints in the practice leaflet and on the practice website. Patients we spoke with were not all aware of the complaints procedure but the majority said they had not needed to make a complaint about the practice. One patient told us of concerns they had raised about the appointment system and about their registration at the practice. They said they had not received a formal response to the first matter. The second matter had eventually been resolved but this had taken some time.

We were provided with an analysis of complaints received in the last year which included a summary of the complaint, action taken, the response and lessons learned.

We looked at the records of two complaints received in the last year. We saw that these were dealt with in a timely manner. The letter of response offered an appropriate explanation and apology. However, there was no reference to the organisations with which the complainant could pursue matters further if they were dissatisfied with the handling of their complaint.

Staff we spoke with were generally aware that patients could complain about the service but some were not aware of the complaints procedure document. We were told that learning from complaints was discussed within the practice and the practice's analysis of complaints recorded a number of instances where discussions had taken place, for example to remind staff about the importance of

Good

Are services responsive to people's needs?

(for example, to feedback?)

customer service principles. However, we did not see evidence of this in the minutes of meetings we reviewed and complaints were not a standing item on the agenda. The practice manager has since shared with us the measures put in place immediately after the inspection in response to these findings. Complaints had been added as a fixed agenda item on the practice's two weekly practice and staff meetings in order that actions taken may be confirmed, followed up and recorded in the minutes.

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 an ethos of being a family friendly, patient-centred service, providing evidence-based care delivered by a team, priding itself on continuous professional development; being part of the local social community; and working with local practices to meet the increasing demands and challenges facing the NHS. Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England. The ethos was reflected in the practice's statement of purpose which set out the practice's aim and objectives, stressing the importance of working in partnership with patients, their families and carers towards a positive experience and understanding and involving them in decision making about their treatment and care. Not all staff we spoke with were aware of this statement and it was not on display for patients. However, 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.

The practice manager showed us the practice strategy document produced in 2006. All employed and attached staff and partners were invited to partake in a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis to identify how to improve the practice. We were told that the practice was about to undertake another such analysis to update the strategy.

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. 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. The policies were subject to regular review and updating, although we noted that some policies were not dated to indicate when they were due for review.

There was a clear leadership structure with named members of staff in lead roles. For example, there were named GP leads for safeguarding, infection control, medicines management, minor surgery paediatrics and gynaecology. We spoke with 14 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. QOF data showed the practice performed above other practices in the local CCG area for the majority of indicators in the year ending April 2014 and in many of them scored 100%. We were told that QOF data was regularly discussed at clinical team meetings and action planning put in place to maintain or improve outcomes. Although we did not see this on the agenda for the majority of meeting minutes we were shown, we noted discussion of QOF at a nurses' meeting in January 2015.

The practice told us about a local peer review system they took part in to benchmark services with neighbouring GP practices in a local 'cluster' network. Benchmarking data showed the practice had outcomes that were comparable to other services in the area, although variations were highlighted and reviewed. For example, local data showed that the practice's hospital referral rates were the highest in the cluster. The practice considered this was due to serving four nursing homes with a high proportion of patients with co-morbidities (the presence of additional conditions with the initially diagnosed illness. Another contributory factor was the relatively high elderly patient population with 2.6% of patients age 85 or over which was higher than the CCG and national average (1.9% and 2.2% respectively). We saw the PHE data which confirmed this.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a repeat audit of the prescribing of Vitamin D to patients with multiple sclerosis (MS), an audit of patients prescribed anticoagulants and an audit of the use of antipsychotics for patients with dementia.

The practice had arrangements for identifying, recording and managing risks. The practice regularly monitored and reviewed risks to individual patients, using specific risk assessment and management tools where appropriate, and updated patient care plans accordingly. A recent fire risk assessment had been completed and the action plan implemented

The practice held weekly clinical governance meetings, fortnightly financial/management meetings and monthly

Are services well-led?

Good

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

administrative staff meetings. There were also periodic nurse meetings. We looked at minutes from a sample of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that staff 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. Staff felt that the practice worked well as a team and provided mutual support.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, induction policy, and disciplinary procedures, which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and health and safety at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, and complaints received. We looked at the results of the latest annual patient survey conducted through the patient participation group (PPG) and saw that the most prominent issue was difficulty in getting an appointment. We saw as a result of this the practice had introduced a new appointment system in November 2014 which included a new telephone system, dedicated phone advice from a GP with a call back within one working day, online booking and online prescriptions and the employment of a new receptionist to increase resources answering phones.

The PPG had an active and long established patient association which met every two months. The group included representatives from various population and ethnic groups. The PPG publicised its activities through the distribution to the practice patient population of its meeting minutes and reports and newsletters twice a year. Its meetings were open to all and advertised on the waiting room media screen. We were shown the action plan agreed with the PPG which included the advancement of plans for premises improvement, with the builder/architect and local authority; and the continuing monitoring of the appointment system. The PPG was part of the local Patients' Participation Network which had been established earlier in 2014, and now operated as an umbrella organisation for all Harrow patient groups.

The two PPG members we spoke with, including the chair, told us that the group had an excellent working relationship with the practice and they welcomed improvements such as doctors calling patients back on the same day to provide telephone advice and patients being able to obtain early morning blood tests. They highlighted the difficulties of doctors managing the increasing size of the patient list which impacted on the service for all patients; continuity of care; and the continuing problem of patients being able to get appointments. They acknowledged the practice was committed to making improvements.

The practice had gathered feedback from staff through staff meetings, appraisals and 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 did not have a whistleblowing policy through which staff could raise suspected wrongdoing at work. Staff nevertheless knew who to approach if they had any concerns.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and saw that they received regular appraisals and learning and development needs were linked to the appraisal process through individual personal development plans.

The practice was a GP training practice and had two GP trainees, one or two F2 doctors (in the second year of their foundation programme) and undergraduate students from three NHS acute trusts. The F2 doctor we spoke with felt they received effective developmental support and supervision.

The practice had completed reviews of significant events and other incidents which included lessons learned. For example, following medical complications that arose in the course of a patient's pain management regime, the practice highlighted the importance of establishing a firm pain

Are services well-led?

Good

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

management plan that all GPs in the practice adhered to in treating the patient. It was also agreed that it was essential that such cases should be discussed by the whole practice team to ensure the patient's treatment was properly co-ordinated and managed. Staff we spoke with confirmed that the outcomes of significant events were discussed with them.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider had not made adequate arrangements to ensure that people who used the service were safeguarded against the risk of abuse because some GPs were not trained to Level 3 in child protection in accordance with national guidance. This was in breach of regulation 11(1) (a)&(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against the risks associated with infection because of shortfalls in the operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections. This was in breach of regulation 12 (1)&(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

How the regulation was not being met:

People who use services and others were not protected sufficiently against the risks associated with unsafe or unsuitable premises because appropriate risk assessments related to the operation of the premises had not been carried out.

This was in breach of regulation 15 (1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.