The Redcliffe Surgery

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Redcliffe Surgery on 9 July 2015. Overall the practice is rated as Good.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time

Our key findings were as follows:

- Patients were protected from risk of harm because systems and processes were in place to keep them safe.
- Staff were clear about reporting incidents, near misses and concerns and there was evidence of communication of lessons learned with staff.
- 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.
- The practice had a clear, patient-centred vision and staff were clear about the vision and their responsibilities in relation to this.
- There was an open culture and staff felt supported in their roles.

Summary of findings

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

- Ensure regular checks carried out on the contents of the medical emergency box are recorded.
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account, linked to the practice's mental capacity act protocol.
- Consider putting in place a practice record of GP revalidation to enable a central overview to be maintained of validation when completed or due.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. 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. Clinical audits were carried out to demonstrate quality improvement in care and treatment and people's outcomes. Patients had access to appropriate health assessments and checks. The practice identified patients who may be in need of extra support and made provision for this.

There were arrangements in place to support staff appraisal, learning and professional development. There was no central practice record of GP revalidations but the practice manager recognised the need for maintaining an overview record and undertook to initiate this.

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 with regard to mental capacity and "best interest" assessments in relation to consent. However, there was a separate mental capacity act protocol and staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand and access the local services available. We also saw that staff treated patients with kindness and respect. The layout and the acoustics of the building presented challenges in maintaining confidentiality but the practice was looking at ways to improve this. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The majority of patients said they found it easy to make an appointment, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. The practice had listened and responded to patient feedback about access to appointments and had taken action to improve this.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.Home visits were available for older patients if required.Flu vaccinations were provided to older people in at-risk groups.The practice carried out proactive care planning with a named doctor offering continuity of care to patients over 65 and worked closely with district nurses who case managed patients with complex needs. There was a primary care navigator on site to support vulnerable older patients and facilitate access to a range of services. The practice had monthly multidisciplinary meetings with social workers, mental health workers and district nurses to discuss at risk patients and used a rapid response service to keep people at home avoiding a hospital admission where possible.The practice took a pro-active approach to end of life care and also provided direct bereavement support.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.Doctors had named areas of responsibility for individual long term conditions such as Diabetes and respiratory disease. All patients with complex long term conditions were allocated a named doctor to offer continuity of care and appropriate follow up.The practice carried out long term condition checks both opportunistically to minimise the inconvenience to the patient, and proactively by inviting patients to an appointment if they disengaged from care. Longer appointments were offered as needed. The practice also offered an in-house anticoagulation service and provided an ambulatory blood pressure monitoring service. Good use was made of available community clinics.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Arrangements were in place to safeguard children from abuse that reflected relevant legislation and local requirements. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Clinical staff worked closely with health visitors to ensure good professional links and regular discussion of at risk children and troubled families. There was antenatal and on site health visiting, including the provision of twice weekly baby clinics. Childhood immunisation rates for the vaccinations given were

broadly comparable to CCG rates in 2013/14. The practice offered easy access to advice and appointments for children with urgent problems throughout the day via a telephone triage and appointment system.

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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. This included a wide range of on-site services such as minor surgery, phlebotomy and psychological therapies for patient convenience and accessibility, and health checks for eligible adults.

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. It had carried out annual health checks for people with a learning disability and offered longer appointments for these patients. The practice ran an enhanced service for the homeless, including open access and longer appointment times and enhanced health checks to allow for poor engagement and complex health problems. The practice had a homeless nursing outreach post based on site and provided services to a 25 bed hostel for 1st stage homeless, offenders, mental health, and substance misuse. The practice also ran an enhanced service for carers to help them to access primary care services at convenient times and offered extra time in appointments to allow for health care checks. There was a co-located 'Carers Hub' on site run by the voluntary sector to ensure wider social care. Arrangements were in place to safeguard vulnerable adults from abuse that reflected relevant legislation and local requirements.

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). Patients in this group were given longer appointments and provided with continuity of doctor and timely follow up. For depression, patients were referred to the primary care mental health service offering a full range of therapies, including on site cognitive behaviour therapy and psychiatric advice, employment support and social connectivity through a third sector provider. The practice regularly worked with

multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. It had increased dementia diagnosis to 67% and had good links with the memory assessment services. The practice screened opportunistically for hazardous and harmful drinking, and referred those with addiction problems to the community drug and alcohol clinic.

Summary of findings

What people who use the service say

The national GP patient survey results published on 8 January 2015 showed the practice was performing broadly in line with local and national averages. There were 88 responses and a response rate of 19%.

- 81% patients said they could get through easily to the surgery by phone compared to the CCG average of 86% and national average of 85%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.
- 95% of patients said the last appointment they got was convenient compared to the CCG average of 91% and national average of 92%.
- 79% patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 74%.
- 66% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards in which patients all had something positive to say about the service experienced. Many commented on the caring nature of the doctors, the polite attitude of the reception staff and the dignity and respect they were shown. Two patients mentioned that they had experienced difficulty in getting short notice appointments.

We also spoke with 11 patients including three members of the patient participation group (PPG) on the day of our inspection. Their experience aligned with that highlighted in comment cards and they mostly very satisfied with the care and treatment provided. Patients with children felt the practice provided an excellent service for children. Two patients raised issues about continuity of care but there were no concerns about gaining access to a female doctor if requested.

Outstanding practice

The practice had developed and piloted the 'Primary Care Navigator' role. The navigator was available on site and could organise befriending, benefits help and signposting to many other services for vulnerable older patients.

The Redcliffe Surgery

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 second CQC inspector, 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.

Background to The Redcliffe Surgery

The Redcliffe Surgery is a single location surgery which provides a primary medical service through a Personal Medical Services (PMS) contract to approximately 10,600 patients in the Kensington and Chelsea areas of West London.

The population groups served by the practice included a cross-section of socio-economic and ethnic groups. A relatively low proportion of patients (5.6% of the practice population) were aged over 75. There were also below average numbers of children cared for at the practice (7% of under 5s and 16% of under 18s). The practice had a higher than average population of working age adults (69%). There are rates of deprivation similar to practice averages across England but the catchment area included areas of both high affluence and high deprivation.

The practice 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.

At the time of our inspection, there were three GP partners and a practice manager at The Redcliffe Surgery. The practice also employed seven salaried GPs, a practice nurse, a health care assistant and nine administrative staff. In addition the practice is a training practice and two GP registrars and a foundation year 2 (FY2) Doctor were on placement at the time of our visit.

The practice is open 8.00am to 6.30pm Monday to Friday, and 9am to 11.30am on Saturday mornings. Appointments are available 8.30am to 8.30pm on Mondays to Thursdays and 8.30am to 6.30pm on Fridays. Saturday mornings the practice offers appointments or walk-in clinics from 9am to 11.30am.

There are also arrangements to ensure patients received urgent medical assistance when the practice was closed. 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 clinically appropriate, will refer the case to the out of hours service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with NHS West London (Kensington and Chelsea, Queen's Park and Paddington) Clinical Commissioning Group (CCG), local Healthwatch and NHS England.

We carried out an announced visit on 9 July 2015. During our visit we spoke with 11 patients and a range of staff including the three GP partners, a salaried GP, a Registrar, the practice nurse, healthcare assistant, the practice manager, and reception/administrative staff. We reviewed 29 comments cards where patients who visited the practice in the week before the inspection gave us their opinion of the services provided. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events and clinical audits. We reviewed personal care plans and patient records and looked at how medicines were recorded and stored.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. There was a designated GP lead for handling significant events. Non-clinical staff told us they would inform the practice manager in the first instance of any incidents and there was also a recording form available on the practice's computer system which was accessible to all staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. The practice carried out biannual reviews of significant events and we saw the minutes of the most recent meeting in May 2015. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a junior doctor mistakenly gave a child patient a flu vaccination by injection rather than intra-nasally. We saw from meeting minutes this was discussed within the practice and it was decided that there should be more training for junior doctors who had started working at the surgery in the flu season.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). One of the GP partners was the designated lead for these and reviewed all alerts and guidelines and emailed anything relevant to the practice to clinical staff. The practice manager was responsible for ensuring all clinical staff were on the mailing list. Where appropriate the alert or guidance would be put on the agenda for clinical meetings for discussion and review of any changes in practice required. We saw evidence of this in the minutes of a meeting in November 2014 when an MHRA drug alert was discussed concerning an antibiotic used to treat urinary tract infections. The minutes recorded follow up action to review patients affected.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and the policy was accessible to all staff. The policy clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare and contact details were also available in the reception area. There were two designated GP partner safeguarding leads, one for children and the other for vulnerable adults. They attended safeguarding meetings when possible and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received up to date training relevant to their role. GPs and the practice nurse had Level 3 child protection training, and reception and administrative staff Level 1. All staff had undertaken training in safeguarding of vulnerable adults.
- A notice was displayed in the waiting room, in practice information leaflets and on the website advising patients that a chaperone service was available, if required. Staff who acted as chaperones had received training for the role and had received a disclosure and barring (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and fire alarm testing and fire drills were carried out. We saw the records for this. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw up to date certificates for this. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as infection control, and legionella. We saw the latest legionella assessment dated December 2014. The practice used the BIRT2 risk assessment tool to identify patients at risk of hospital admission, particularly those with long term conditions. Care plans and risk registers were in place for patients assessed as high risk.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and

tidy. The senior GP partner was the nominated infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control policy in place. All staff received induction training about infection control specific to their role. The infection control lead and the practice manager had completed recent refresher training. They had subsequently cascaded relevant information to all practice staff at in-house training in November 2014, and we saw the record of this. Regular infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. We were shown an infection control audit dated December 2014 and noted the practice was in the process of implementing the recommendations.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. There was a process for ensuring that medicines were kept at the required temperatures. We saw that checks of fridge temperatures were carried out daily and recorded. There were arrangements in place to support the management of patients on high risk medicines, including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions.
- Recruitment checks were carried out and the four files we reviewed showed that appropriate pre-employment checks had been undertaken. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, one of two locum doctors' files we looked at did not have a record of the proof of identity check on file.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for non-clinical staffing. The practice manager liaised with the GP partners in planning and managing the GP workforce and this was reviewed at monthly business management meetings. There were appropriate arrangements in place with locum agencies if, exceptionally, clinical cover was required, including pre-employment checks to ensure the suitability of locums to practice. The practice had experienced difficulty over the last year in recruiting a practice nurse and this had impacted on nurse-led services. However, a nurse had been successfully recruited shortly before the inspection and the practice was confident of delivering a quality nursing service once the new nurse was fully inducted within the practice.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There was also a panic button in the reception area All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. The emergency box was labelled with the contents and we were told the box was checked regularly. However, no record was kept of these checks. We found open dressing tape and cotton buds in the box but these were removed immediately by the nurse. We were told that the practice would be reviewing the contents of the box following feedback from the basic life support trainer, for example to replace current airways and tourniquets with disposable items.

The practice had a comprehensive disaster recovery and business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and checks of patient records.

The GPs 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. There was a nominated GP lead for clinical education who ensured new guidance was reviewed by all clinicians and action taken as appropriate. We saw evidence of this in the minutes of weekly clinical meetings we looked at. The guidelines and related protocols could be called up on the practice's computer system during patient consultations.

The practice had access to a local rapid response team to keep people at home avoiding unplanned hospital admission where possible.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results from the latest data available were 86.7% of the total number of points available, with 9.7% exception reporting. For six clinical indicators the practice scored the maximum points available all above the CCG and national average. This practice was not an outlier for QOF (or other national) clinical targets. Data from 2013/14 showed the practice scored less well in some areas, for example:

- Performance for diabetes related indicators was below the CCG and national average: 81.1% compared to 86.4% and 90.1% respectively;
- The percentage of patients with hypertension having regular blood pressure tests was below to the CCG and national average: 72.1% compared to 80.8% and 83.1% respectively;
- Performance for depression related indicators was below the CCG and national average: 52.9% compared to 78% and 86.2% respectively; and
- Performance for peripheral arterial heart disease related indicators was below the CCG and national average: 76.8% compared to 90.3% and 91.2% respectively.

The practice regularly reviewed its QOF performance. We were told a change to a new computer system may have impacted on some scores but the practice had targeted areas for improvement. The practice data at the time of the inspection indicated they were on course for improvement in general and in some previously lower scoring areas in particular, for example in relation to diabetes and hypertension.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. The practice provided evidence of four clinical audits completed in the last two years. Three of these were completed audits where the improvements made were implemented and monitored. For example, an audit of patients receiving anti-coagulant medicine led to better identification and management of patients on anti-coagulants and the introduction of new practice guidelines for their treatment. This included initiating and stopping the medicine, the interaction with food and other drugs and a range of advice to patients, such as before surgery. The practice participated in applicable local audits, such as a CCG monitoring of antibiotic prescribing.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction policy and programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice

development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff, apart from those recently recruited, had had an appraisal within the last 12 months. There was a rolling programme of annual appraisals based on the anniversary of date of employment. Alongside appraisals the practice was conducting a training needs analysis through a series of one to one meetings with staff. The aim was to produce a training plan to ensure the practice had the right skills mix to meet the requirements for the local out of hospital services programme which it would be joining in August 2015. It would also enable the practice to develop a training matrix to provide an overview on staff training, a need for which had been identified as part of an external human resources audit.

- All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.) There was no central practice record of revalidations but the practice manager recognised the need for maintaining an overview record and undertook to initiate this.
- As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with. One of the GP partners was the their trainer and also the programme director for GP training at a local NHS acute hospital.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets was also available. All relevant information was shared with other services in a timely way, for example when people were referred to hospital and community services. The service used a national referral system for this. Patients who were placed on the urgent two week referral pathway, where there was a possibility that symptoms could indicate cancer, were advised to ring the hospital after two weeks if they had not heard from them about the referral.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team (MDT) meetings took place on a monthly basis to consider patients with complex needs, including those with long term conditions and mental health problems who had been assessed as at risk. There were quarterly meetings with the palliative care team to review patients receiving end of life care. Care plans were routinely reviewed and updated following MDT meetings.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. 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 with regard to mental capacity and "best interest" assessments in relation to consent. However, there was a separate mental capacity act protocol and staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. The consent policy made provision for documenting consent for specific interventions, for example, for expressed consent (written or verbal) for any procedure which carried a risk that the patient was likely to consider as being substantial. A note would be made in the medical record detailing the discussion about the consent and the risks. We saw evidence of this in patient records we reviewed.

Patients with a learning disability and mental health problems (including those with dementia) were supported

Good

Are services effective?

(for example, treatment is effective)

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) and recorded the patient's preferences for treatment and decisions**.**

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients receiving end of life care, carers, those at risk of developing a long-term condition; and those requiring advice on their diet, smoking and alcohol cessation and those in at risk groups including vulnerable children and adults, patients with learning disabilities and mental health problems. Patients were then signposted to the relevant service. For example, obese patients were referred to weight loss and exercise classes and offered access to a dietician if appropriate. The practice health care assistant provided advice to identified smokers at a smoking cessation clinic.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme in 2013/14 was 66%, which was below the CCG average of 73% and the national average of 77%. The practice had taken steps to improve uptake including the booking of extra nurse clinics. The practice had also employed students to telephone patients without a smear test in their record to invite them for a test, or document in their record when the last test was done if they could provide evidence of the test done privately. We were told the number of smears had increased but the number of eligible patients had risen so the percentage target had remained static. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There was an uptake of 40% and 52% respectively for eligible patients in the last 12 months.

Childhood immunisation rates for the vaccinations given were broadly comparable to CCG rates in 2013/14. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 62% to 84% and five year olds from 59% to 93%. More recent practice data for the period April to June 2015 the practice had achieved the 70% target for immunisation rates in the first quarter of the year for both age groups. Flu vaccination rates for the over 65s were 49%, and at risk groups 66%. These were slightly below national averages.

Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Health checks previously offered to new patients had been suspended in the past year due to a lack of nursing resources to support this activity. However, all patients were asked to fill out a new patient questionnaire and any patients flagged as having ongoing medical needs or on repeat medication were invited in to meet a doctor.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were on most occasions courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. We noted that consultation and treatment room doors were closed during consultations. However, some of the conversation taking place in these rooms could be overheard. The practice recognised that this was an issue and had considered possible solutions, including sound proofing. They had applied to the CCG for an improvement grant for this but were awaiting the outcome.

In all 29 patient CQC comment cards we received, patients had something positive to say about the service experienced. Many commented on the caring nature of the doctors, the polite attitude of the reception staff and the dignity and respect they were shown. Two patients mentioned that they had experienced difficulty in getting short notice appointments. We also spoke with 11 patients, including three with children, one accompanied by their carer and three members of the patient participation group (PPG) on the day of our inspection. Their experience aligned with that highlighted in comment cards and they were mostly very satisfied with the care and treatment provided. Patients with children felt the practice provided an excellent service for children. One or two patients raised issues about continuity of care but there were no concerns about gaining access to a female doctor if requested.

Results from the national GP patient survey showed patients were, in most respects, happy with how they were treated and that this was with compassion, dignity and respect. The practice was at or above average for the majority of satisfaction scores on consultations with doctors but below for some of the scores for nurses. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 89% and national average of 87%.
- 85% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 99.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 75% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.

Staff told us that translation services were available for patients who did not have English as a first language. When advanced notice was received of the need for an interpreter reception staff booked this and arranged a double appointment for the patient. The practice website had a facility to translate the content into a wide range of languages.

Patient/carer support to cope emotionally with care and treatment

The practice facilitated patient access to a number of support groups and organisations, for example patients with addiction problems were referred to the local community drug and alcohol clinic.

Good

Are services caring?

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers. 135 patients on the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice participated in a co-located local 'carers hub' which was held on site weekly, run by the voluntary sector to ensure wider social care needs were met.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer condolences and provide advice on how to find a support service, for example the local bereavement counselling service. The practice worked to the Gold Standards Framework in managing and supporting patients receiving palliative care.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice was participating in the CCG's 'whole systems design' as a pilot practice to provide coherent and integrated health and social care services to older adults in West London.

Services were planned and delivered to take into account the needs of different patient groups and to help provide and ensure flexibility, choice and continuity of care. For example:

- There were disabled facilities and translation services available. For patients who were deaf or hard of hearing the practice could obtain the services of a sign language interpreter for consultations.
- There were longer (double) appointments available for carers (to carry out health checks) people with long term conditions and complex needs, and vulnerable patients, including those with a learning disability, and mental health problems.
- The practice was a member the North West London Integrated Care Pilot, a scheme to provide integrated care between GPs and other community health workers for diabetic patients, and/or patients over the age of 75.
- The practice carried out proactive care planning with a named doctor offering continuity of care to patients over 65, and worked closely with district nurses who case managed patients with complex needs.
- There was antenatal and on site health visiting, including the provision of twice weekly baby clinics.
- The practice ran an enhanced service for the homeless to facilitate care for this group, including those street homeless of no fixed abode. The practice have had a homeless nursing outreach post based on site and provided services to a local 25 bed hostel for 1st stage homeless, offenders and people with mental health and substance misuse problems.
- There was an on-site cognitive behaviour therapist and community psychiatric nurse for the referral and case management of patients experiencing mental health problems.

Access to the service

The practice was open 8.00am to 6.30pm Monday to Friday, and 9am to 11.30am on Saturday mornings. Appointments were available 8.30am to 8.30pm on Mondays to Thursdays and 8.30am to 6.30pm on Fridays. Saturday mornings the practice offered appointments or walk-in clinics from 9am to 11.30am. Patients could book 'routine appointments'**:** **th**ese were for non-urgent, new or follow-up medical matters, for which the practice endeavoured to offer access to a doctor within 48 hours and to a nurse within 24 hours. The practice also offered routine telephone (teleconsult) appointments**.** These were a new type of appointment being trialled to deal with routine ongoing problems, for example where follow up was required and the patient had already seen the doctor. Urgent appointments could be made on the day for patients who were unwell and needed to be seen. A telephone number was taken and the duty doctor called the patient back, and if appropriate brought them in to be seen in a reserved appointment slot. There were online services including appointment booking and prescription ordering. The practice also used text messaging and email to communicate with patients.

People we spoke to on the day were mostly complimentary about the appointments system. This aligned with results from the 2014-15 national GP patient survey, which showed that patient's satisfaction with how they could access care and treatment was comparable to or better than local and national averages. For example:

- 95% of patients said the last appointment they got was convenient compared to the CCG average of 91% and national average of 92%.
- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and national average of 76%.
- 81% patients said they could get through easily to the surgery by phone compared to the CCG average of 86% and national average of 85%.
- 79% patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 74%.
- 66% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.

The majority of patients we spoke with on the day were able to get appointments when they needed them but two

Good

Are services responsive to people's needs?

(for example, to feedback?)

mentioned difficulty in getting appointments at short notice. We also spoke with three members of the Patient Participation Group (PPG) who also commented favourably on the appointments system.

The practice had also reviewed patient satisfaction with the appointments system in the light of feedback from the PPG patient satisfaction survey conducted in 2013-14. The action plan put in place as a result of the survey included: increasing access to online appointment booking; reducing waiting time when waiting to see the doctor; reviewing the system for patients to see the doctor of their choice; and further access improvements to the telephone system.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. There were additional policies to support staff in the handling of concerns covering whistleblowing, bullying and harassment and equal opportunities.

We saw that information was available to help patients understand the complaints system. The complaints policy and procedure was on display on the notice board in the patient waiting area. There was also advice about making a complaint in the practice leaflet made available to all patients and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at the information provided by the practice on all complaints received in the last 12 months, including those received verbally and in writing. We found these were satisfactorily handled, dealt with in a timely way, and showed openness and transparency in dealing with the complaint. Complaints and their outcomes were discussed with appropriate staff and with the practice team to communicate wider lessons learned. We saw meeting minutes where complaints were discussed, for example where prescribing practices were reviewed as a result of lessons learnt from a complaint.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. The practice carried out an annual review of all complaints and identified themes and an action to address common areas of complaint. For example, it was found that repeat prescriptions were not being consistently updated following receipt of hospital letters. This was subject to a significant event analysis and it was agreed as a result that all discharge summaries would be sent to the patient's usual GP to action. If urgent the duty doctor would action on the day.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to 'make Redcliffe a "destination practice",' where people want to come and be seen to have their healthcare needs met with highest quality person-centred care. This had recently been drawn up alongside a 'practice charter' developed with input from both clinical and administrative staff following discussion at staff away days. We were shown the latest draft of the vision and charter which was due to be finalised before being communicated to patients.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the practice's vision and good quality care. This outlined the structures and procedures in place and ensured:

- there was a clear staffing structure and that staff were aware of their own roles and responsibilities;
- practice specific policies were implemented and systematically reviewed and updated and were available to all staff;
- a comprehensive understanding of the performance of the practice;
- a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements; and
- there were robust arrangements for identifying, recording and managing risks and issues, and implementing mitigating actions.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing broadly in line with national standards across the majority of indicators. QOF performance was reviewed on an ongoing basis at clinical meetings to ensure the quality of patient care was kept under continuous scrutiny and enable improvement action to be taken in targeted areas.

There were weekly clinical meetings, bi-monthly administrative staff meetings and monthly 'all practice' meetings to disseminate relevant information throughout the practice and give staff the opportunity to raise issues. We saw a selection of minutes of these meetings.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. They said there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so, and felt supported if they did. We also noted that team away days were held periodically and we saw a summary of the discussion and agreed action of the away day held in March 2015 and the agenda for the meeting in July 2015. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The practice manager was responsible for human resource (HR) policies and procedures and had been working with an external HR provider to review and update these. 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 being updated as part of the external review and would be available to all staff. It included sections on work standards, sickness, on equality, harassment, whistleblowing and health and safety at work. Staff we spoke with knew where to find these policies if required.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met on a regular basis and there was also a virtual PPG to give patients the flexibility of staying in touch virtually through an online patient discussion forum. The PPG reviewed with the practice the results of patient surveys and agreed action plans for improvements. For example, the most recent plan included

Are services well-led?

Good

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

action to improve access to appointments by updating the telephone system, providing additional reception staff support at peak times and training them in call handling and signposting patients to appropriate services. The practice had identified as part of its challenges and plans the aim of engaging patients' views through a 'patients as partners" approach. There was an action plan in place to achieve this, including the appointment of a public and patient engagement (PPE) champion to support the PPG.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had developed and piloted the 'Primary Care Navigator' role. The navigator was available on site and could organise befriending, benefits help and signposting to many other services for vulnerable older patients. The practice also participated in the CCG's 'whole systems design' as a pilot practice to provide coherent and integrated health and social care services to older adults in West London. This involved the use of care plans and case management, a named GP for all housebound patients and enhanced care from receptionists. In addition the practice had been in a pilot for Children's hubs which involved case-based learning in a multidisciplinary setting to address the needs of families with children with high use of A&E for care.

The practice had participated in a recent audit of patients with long term mental health issues which showed their physical health to be within expected range for the population and suggested good care for physical health at the surgery. The audit showed 40% of these patients had unmet social care needs and the practice would be taking part in a CCG led pioneer project which would look to address these wider needs.