The Belgravia 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 a comprehensive inspection of Belgravia Surgery on 20 May 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 across all areas we inspected were as follows:

- Arrangements were in place to ensure patients were kept safe. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice guidance.
- We saw from our observations and heard from patients that they were treated with dignity and respect and all practice staff were compassionate.
- The practice understood the needs of their patients and was responsive to them. There was evidence of continuity of care and people were able to get urgent appointments on the same day.
- There was a culture of learning and staff felt supported and could give feedback and discuss any concerns or issues with colleagues and management.

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. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care, 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.

Summary of findings

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. 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There was a register for older people who have complex needs, required additional support or were housebound and care plans were in place to ensure these patients and their families receive coordinated care and support. One GP was also the 'end of life care' lead for the CCG and carried out weekly wards rounds to local care and nursing homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors.

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

Summary of findings

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 reflects the needs for this age group.

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 held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). 92% of people experiencing poor mental health had received an annual physical health check. 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.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection and received 30 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Patients said the care was good and staff were friendly, professional and accommodating and that all staff treated them with dignity and respect.

Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care. The national GP patient survey found that 89% of respondents described their overall experience of the practice as good and 88% said that they would recommend the practice to someone new.

The Belgravia 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 and an expert by experience.

Background to The Belgravia Surgery

Belgravia Surgery provides GP primary care services to approximately 6,500 people living in Westminster. The practice is staffed by three GPs, two male and one female who work a combination of full and part time hours. The practice is a training practice and employs one trainee GP registrar one nurse, a practice manager and seven administrative staff. The practice holds a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 8am to 6.30pm Monday to Fridays. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provides a wide range of services including clinics for diabetes, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provides health promotion services including a flu vaccination programme, travel vaccinations and cervical screening.

The practice is located in an area where the population is relatively old, with 65% residents over 70 years of age. The population is ethnically diverse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired

Detailed findings

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

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 20 May 2015.

During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

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. Administrative staff and receptionists told us they would inform the practice manager and write a brief statement in the incident book regarding any significant event or incident that takes place. These were usually discussed on the day they occurred and always discussed at the weekly clinical meeting. We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw there had been a recent incident where the wrong patient was booked for a review with a GP due to having the same surname. The practice immediately implemented a double checking process of asking for the patients both names and date of birth. All staff were informed and patients were advised of the change and why.

The practice carried out an analysis of the significant events (SEA) bi-annually which included identifying any themes and learning points.

National patient safety alerts were disseminated by the practice manager to the relevant practice staff by email through the practices computer system messaging facility. Staff we spoke with told us of recent alerts they had discussed regarding a diabetic drug.

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 patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. All staff had received relevant role specific training on safeguarding children and clinical staff had received training in adult protection. However, most non clinical staff we spoke with knew how to recognise signs of abuse in older people and vulnerable adults. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located in intranet pages and displayed on the walls in reception. Since our inspection we have received evidence to confirm all staff have now completed safeguarding adults training. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role. We were told that chaperone training had not been undertaken by these staff members and they had not been Disclosure and Barring Service checked as they would never be left alone with a patient. However, all staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination.
- The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on all computer desktops for all staff. There were various staff risk assessments carried out such as to asses stress. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. However, on the day of our inspection we noted that portable electrical equipment testing (PAT) was last carried out in 2013. Since our inspection we have received information to confirm that all equipment was PAT tested in June 2015. A schedule of testing is now in

place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in January 2014.

- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. Monthly infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example we saw a recent audit had identified that the practice needed a deep clean. We saw records to confirm this had been carried out. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Medicines were stored in medicine refrigerators in the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings, for example the prescribing of antibiotics. The practice takes part in monthly benchmarking meetings with other GP practices in Westminster, which periodically is attended by the CCG's Medicine Management Team who report on prescribing levels at each practice.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. They had employed an additional salaried GP who was due to start in July. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The reception manager occasionally provided cover in reception during busy periods.

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. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice did not have a defibrillator available on the premises and had not carried out a risk assessment. There was oxygen with adult and children's masks. There was also a first aid kit and accident book available. 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 practice had a comprehensive 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 GPs told us they attend "hot topics" courses annually and feed back to the weekly clinical meeting. The practice had access to guidelines from NICE and any changes were cascaded to the GPs, nurses and registrar who used this information to develop how care and treatment was delivered to meet needs.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. We reviewed some clinical meeting minutes and confirmed that this occurred. For example, the practice had recently received a guideline on management of people with COPD and the practice had identified where improvements could be made to their spirometry testing for patients. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw that where a clinician had concerns they would 'instant message' another clinician to get a second opinion.

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. GPs told us they were committed to maintaining and improving outcomes for patients, however we noted that the QOF report from 2012-2013 showed the practice scored 98% and for 2013-2014 indicated the practice had not maintained this level of achievement scoring 89% which was 5% above the CCG average but 4% below the England average. They had a 14.6% exception reporting.

The QOF data showed;

- Performance for diabetes related indicators was 79% which was 0.4% above the CCG but 10.2% below national average.
- The percentage of patients with hypertension having regular blood pressure tests was 64% which was 18.6% below the CCG average.
- The dementia diagnosis rate was 100%, which was 17% above the CCG and 6.6% above the national averages.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been two clinical audits completed in the last year where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, one GP had audited the prevalence of Asthma and COPD and found it was much lower than the national prevalence. They looked at all patients receiving an inhaler without a respiratory diagnosis. There were 78 patients, of these 14 had either COPD or Asthma. The GP asked the team to be vigilant for undiagnosed patients, especially considering chronic smokers. After re-audit they found there was an increase in diagnosis for both conditions by 1.5%. The practice also decided to purchase a spirometer to further improve their diagnosing of these conditions.

Effective staffing

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

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety.
- 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 had had an appraisal within the last 12 months

Good

Are services effective?

(for example, treatment is effective)

- Staff also had to complete regular mandatory courses such as annual basic life support and health and safety training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics.
- Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example, reception staff told us they had received information technology and customer service 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 and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

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 meetings took place on a quarterly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. A care coordinator was available at the practice two days a week and smoking cessation advice was available from a local support group. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 69%, which was below the CCG average of 72% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and the care coordinator had recently taken on this task to help improve these rates. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 74% to 85% and five year olds from 67% to 84%. Flu vaccination rates for the over 65s were 63%, and at risk groups 40%. The practice was aware that these were below the CCG and national averages and had put in processes to try to improve these outcomes.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and 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.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 30 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. The practice was in the process of setting up a patient participation group (PPG) and we saw that the first meeting was planned for June 2015. Since our inspection we have received evidence to confirm that the first meeting occurred.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and the friends and family survey. The evidence from both these sources showed patients were satisfied with their experience at the practice. For example,

- 89% of patients who responded described their overall experience as good as compared to the local average of 80% and the national average of 85%.
- 93% of practice respondents saying the GP was good at listening to them as compared to the local average of 84% and the national average of 88%.
- 90% said the GP gave them enough time as compared to 85% and 83% respectively for the CCG and the national average
- 87% said the last nurse they spoke to was good at treating them with care as compared to the local average of 89% and the national average of 91%.
- 88% patients said they found the receptionists at the practice helpful which were comparable to the CCG and national averages.

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 rated the practice good in this area. For example, data from the national GP patient survey from 2014 showed 84% of practice respondents said the GP involved them in care decisions compared to 76% for the CCG and 81% nationally. The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received with all GPs. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete a carer's forms where appropriate and there were written information available for carers to ensure they understood the various avenues of support available to them.

There was a system of support for bereaved patients both provided by the practice and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. People were given the option to be referred for bereavement counselling or signposted to a

Good

Are services caring?

support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Deaths of patients were discussed at the weekly clinical and monthly practice meetings.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised.

Patients over 75 years had a named GP to co-ordinate their care and are offered an annual health check and vaccinations such as Influenza, Pneumococcal and Shingles. There was a register for older people who have complex needs, required additional support or were housebound and care plans were in place to ensure these patients and their families receive coordinated care and support. Patients on medications had their blood and physical examination every six months. Older patients at risk of admission had their care plans reviewed every three months. Further, one GP was the clinical lead for End of Life care for the CCG. They also carried out weekly ward rounds to a local nursing home and care home for older

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed. They are reviewed every six months and we saw where results are outside the normal range appropriate action was taken. They were then monitored closely before patients were returned to normal review periods.

The practice ran a weekly mother and baby and baby immunisation clinics which provided an opportunity for mothers to express any concerns to the GP or nurse that they may have. GPs told us they liaise regularly with health visitor who also attend some Multi-Disciplinary Team Meetings. The practice offered appointments on the day for all children under 5's when their parent requests the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they promote sexual health screening.

The GPs told us that patients whose circumstances may make them vulnerable such as the homeless, those under safeguarding, those that have issues with employment or people with learning disabilities were offered regular health checks and follow-up. They said they would also refer them to other agencies including homeless shelters, citizens' advice bureaus, social services, Improving Access to Psychological Therapies (I)APT, Mind, and Westminster Carers Group. Any patients who were deemed vulnerable were also brought to the weekly clinical meeting by the relevant clinician and discussed.

The practice offered working aged patients access to extended appointments Monday to Friday as they opened at 8am. They also offered on-line appointments, online ordering of repeat prescriptions, and telephone consultations to speak with the GP or nurse in relation to test results. The GPs said they were aware of work-place stress and they would offer patients in this group in-house counselling, access to IAPT as well as practical advice regarding other agencies to contact.

The practice had a register of patients experiencing poor mental health and the prevalence 0.9% (national 0.8%) These patients were invited to attend annual physical health checks and 93% had been reviewed in the past year. They also had a primary care liaison nurse for mental health based at the practice one day a week. Their role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We saw they would refer patients to Improving Access to Psychological Therapies (IAPT), support patients themselves or refer directly to the acute brief assessment team in the local hospital.

The dementia prevalence at the practice was 0.7% (national 0.6%) and 92% had had face-to-face dementia reviews in the last year.

The GPs told us they were comfortable to initiate discussion about weight. The practice had an obesity register and would refer patients to "My Action", exercise sessions in the local gym.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. Some treatment and consultation rooms were on the first and second floors, which were accessible via a lift. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

The practice was open from 8.00am to 6.30pm Mondays to Friday which was particularly useful to patients with work commitments. The telephones were manned from 8.00am to 6.30pm Mondays to Fridays, a recorded message was available at all other times. Appointment slots were available throughout the opening hours. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Feedback from the national GP survey published in 2014 was positive about the appointment system. For example;

- 84% of respondents described their experience of making an appointment as good and
- 88% were satisfied with the surgery's opening hours.

Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment stating they could always get an appointment when needed although they said it was sometimes difficult to get through to the surgery on the phone. The practice manager told us they had arranged for a new telephone system to be installed to address the issue.

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. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample complaints received in the last 12 months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, we saw that where a patient had complained about not getting their repeat medication on time the practice investigated and found there had been issues with scanning clinical letters. A review was carried out and a new procedure implemented.

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 manager told us their vision was to provide a flexible high standard of health care in a caring environment with particular emphasis being placed on disease prevention and management. They said they aimed to deliver a high standard of patient care, be committed to patient needs and be transparent and accountable to them. Staff we spoke with understood the vision and said they felt the practice delivered high quality care, promoted good outcomes for patients and continually tried to make improvements. We found staff were clear about their responsibilities in relation to providing good care at the practice.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. All seven policies and procedures we looked at had been reviewed annually and were up to date.

The practice held weekly management meetings which were attended by the partners and the practice manager. We looked at notes from these meetings and found that performance, quality, training and accounts had been discussed.

One GP partner was on the board of the Clinical Commissioning Group (CCG). We saw that information from this forum was fed back to practice staff at monthly practice meetings.

The practice had a comprehensive understanding of their performance. They attended a monthly peer review village meeting with other practices and used the Quality and Outcomes Framework (QOF) to measure their performance, which showed it was performing in line with national standards. Staff told us QOF data was regularly reviewed and discussed at the practices weekly meetings.

There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements. Further, there were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records.

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 prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always takes 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 and that there was an open culture within the practice. They said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. 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

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through patient surveys, friends and family test and complaints received. We looked at the results of the in-house patient survey from 2014 and saw that one area reviewed was patient's dissatisfaction with the length of time it took to get through on the telephone. As a result the practice had installed a new telephone system with extra lines line. The practice was in the process of setting up a patient participation group (PPG) and we saw that the first meeting was planned for June 2015.

The practice had also gathered feedback from staff through staff meetings and appraisals. 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

Are services well-led?

Good

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

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 they were a training practice and at the time of our inspection employed one trainee GP registrar. The GP trainer also provided apprenticeship clinics and recorded teaching sessions for trainee GPs employed at other local practices.

The practice had also set up an apprenticeship scheme for administrative staff and was in the process of recruiting the first trainees. Since our inspection the practice manager has confirmed that administrative apprentices have now started working at the practice.