The Pembridge Villas 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.

Summary of findings

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Overall summary

The Pembridge Villas Surgery provides GP led primary care services to approximately 9800 patients living in the surrounding areas of Notting Hill and Westbourne Green in the West London borough of Kensington and Chelsea. The population demographics for the area included a higher proportion of 20-39 year olds living in the area, and the most widely spoken languages after English are French and Arabic.

The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures; and treatment of disease, disorder and / or injury.

We carried out an announced inspection on 22 May 2014. During our inspection we spoke with patients, the GPs, practice manager, assistant practice manager, nurse, phlebotomist, health care assistant and reception staff. Patients we spoke with told us they were happy with the service they had received. Staff we spoke with told us they felt supported in their role and enjoyed working at the practice.

The practice provides good care but some areas of the service require improvement, including respecting patients' privacy and dignity during examinations. Some staff had not received training in infection prevention and control and, protecting vulnerable adults from the risk of abuse.

Systems were in place to ensure clinical staff received information required to deliver good clinical care. There was evidence that the practice had learnt from significant events to minimise the risks to patient safety and systems were in place to safeguard children from abuse. Clinical staff had completed audit cycles to monitor and improve the service. There were clear leadership and governance arrangements in place, with staff describing a positive culture of openness and support within the practice.

Patients were able to access the service via booked appointments or daily walk-in clinics. There were some arrangements in place to respond to the needs of different population groups including seasonal flu clinics for older patients, immunisation clinics for babies and, health clinics to review people with long term conditions. The practice had developed special expertise in caring for homeless patients.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Many aspects of the service were safe but some areas required improvement. There were systems to ensure clinical staff were provided with information required to deliver safe clinical care. Processes were in place to raise concerns and there was a culture of learning from incidents within the organisation. The practice assessed and monitored risks relating to the environment, and staff followed appropriate infection prevention and control practices.

The practice had a business continuity plan which detailed the arrangements for dealing with foreseeable emergencies. Staff demonstrated awareness of how to respond in a medical emergency and regular checks of resuscitation drugs were undertaken to ensure they were fit for purpose. Medicines kept on the premises were suitably stored and checked regularly to ensure they were fit for use. Staff were trained and aware of their responsibilities for safeguarding children.

Some areas of the service required improvement. There were expertise within the team for treating vulnerable patients, however staff had not received vulnerable adult training. There was no schedule of the emergency equipment kept in a portable emergency bag to ensure checks were regularly performed and, some clinical staff had not completed training in the prevention and control of infection.

Are services effective?

The practice was effective in monitoring and improving outcomes for patients. The practice participated in clinical audits and external peer group meetings and this contributed to improvements in areas of clinical care. The practice followed National Institute for Health and Care Excellence (NICE) guidance around the treatment for patients with long term conditions such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Coronary Heart Disease (CHD).

Staff kept up to date through appraisals and on-going training. The practice worked with other practices to develop the service. Patients were given information and support regarding health promotion and prevention.

Are services caring?

Many aspects of the service were caring but some areas required improvement. All the patients we spoke with, and the comments we received were complimentary of the care and service that staff

Summary of findings

provided. Patients used the NHS Choices website to provide feedback and results from the GP survey were overall positive, with most patients stating they felt listened to by the GP. Many patients felt staff supported them to make choices and decisions for themselves. We found patient's care was planned and delivered in a way that met their individual needs.

An area we identified as requiring improvement related to patient's privacy and dignity. The practice did not have privacy screens in most consultation rooms and, curtains or blinds were not present in one consulting room to respect patients' privacy and dignity during consultations.

Are services responsive to people's needs?

Patients' needs were appropriately assessed and met. This included patients with long term conditions. Some staff had expertise in treating homeless patients and the practice offered a specialist service to a learning disability home and women's refuge.

The practice offered weekday walk-in clinics and pre-booked appointments, and the premises was accessible to patients with mobility difficulties. Patients told us they found it easy to access the service. The practice had listened to feedback from the recent practice survey and Patient Representative Group, and made changes to improve the service. Information about the complaints process was available for patients and the practice had learned from patients' experiences, concerns and complaints to improve the quality of care.

Are services well-led?

Governance arrangements were in place with identified leads for specific areas and support for staff to develop their roles in order to improve patient care. Staff described a positive culture of openness and support within the practice. The practice were involved in the Patient Representation Group and learned from patients' experiences, concerns, and complaints to improve the quality of care. The practice had systems in place to identify risk, such as health and safety assessments and a business continuity plan.

Summary of findings

The six population groups and what we found

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

Older people
The practice had some services to support and review older patients, such as the seasonal flu clinic and home visits. Patients over the age of 75 had a named GP.

People with long-term conditions
The practice responded to the needs of patients with long term conditions, and followed national guidance for the treatment for these groups of patients. Care was tailored to patients' needs and the practice had a multi-disciplinary approach. The practice's Patient Representative Group (PRG) included patients with long term conditions.

Mothers, babies, children and young people
The practice responded to the needs of babies and children. The practice held childhood immunisation clinics and protocols were in place to identify which children needed to be called in for vaccinations. GPs met with health visitors to discuss children identified as 'at risk'. The practice's Patient Representative Group (PRG) represented pregnant patients and mothers with children. The practice had some services to support young people. New patients aged 16-25 years were routinely offered chlamydia screening during their new patient health check.

The working-age population and those recently retired
The practice responded to the needs of the working-age population by offering flexible access to appointments, and online facilities for requesting repeat prescriptions, registering with the practice and providing feedback. New patients aged 16-25 years were offered chlamydia screening during their new patient health assessment.

People in vulnerable circumstances who may have poor access to primary care
The practice supported patients in vulnerable circumstances. The practice supported patients from a local learning disability home, a women's shelter, and some staff had developed expertise in treating homeless patients. The practice conducted a drug dependency clinic and received multi-disciplinary input. The practice's Patient Representative Group (PRG) represented patients in vulnerable circumstances

Summary of findings

People experiencing poor mental health

The practice had some services to support and review patients with mental health problems, such as multi-disciplinary input and representation at the practice's Patient Representative Group (PRG).

Summary of findings

What people who use the service say

Most patients we spoke with told us that they were happy with the service provided at the practice. Members of the patient representative group told us that the service was proactive in listening to and addressing the needs of patients. Comment cards received were positive, with patients complimenting the staff and service they had received.

Areas for improvement

Action the service MUST take to improve

The practice did not have privacy screens in most consulting rooms to respect patients' privacy and dignity during consultations.

Action the service COULD take to improve

The practice could make arrangements for all staff to receive training in the safeguarding of vulnerable adults and, for GPs to receive training in infection prevention and control.

The practice could introduce protocols for checking emergency equipment.

The practice could offer an online appointment booking system.

The practice could introduce formal systems for supervision of administrative staff.

Good practice

Our inspection team highlighted the following areas of good practice:

In addition to booked appointments the practice offered two walk-in clinics on Monday, Tuesday, Thursday and Friday, and one walk-in clinic on Wednesday.

The practice had developed expertise in caring for homeless patients, and received support from the community psychiatric nurse and consultant psychiatrists during multidisciplinary meetings. Homeless patients were offered an extended registration health check with screening for blood borne viruses, vaccinations and referral to other services such as mental health and drug and alcohol services if required.

The Pembridge Villas SurgeryThe Pembridge Villas Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The lead CQC inspector was accompanied by a CQC inspector and two specialist advisors; a GP and a Healthcare Manager. They were all granted the same authority to enter The Pembridge Villas Surgery as the CQC inspectors.

Background to The Pembridge Villas Surgery

The Pembridge Villas Surgery provides GP led primary care services to around 9800 patients living in the surrounding areas of Notting Hill and Westbourne Green, in the West London borough of Kensington and Chelsea. The population demographics for the area include a higher proportion of 20-39 year olds living in the area, and the most widely spoken languages after English are French and Arabic.

The practice operated from a converted house and had made adjustments to ensure that the property was accessible to patients with mobility needs. Following the closure of another GP practice some of the patients had transferred to the practice. To cope with the additional number of patients the practice was recruiting an additional nurse. The practice had a good working relationship with other providers in the area, including other GPs, a learning disability home and a women's shelter.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions

Detailed findings

- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before the visit we reviewed a range of information we held about the service and asked other organisations, including NHS England and the West London Clinical Commissioning Group (CCG), to share what they knew about the service. We carried out an announced visit on 22 May 2014.

During our visit we spoke with a range of staff including the two GP Partners, two salaried GPs, practice manager, assistant practice manager, nurse, phlebotomist and reception staff. We also spoke with eight patients who used the service, three members of the patient participation group, and the manager of a local learning disability home. We observed how patients were being cared for and talked with carers and/or family members. We reviewed four comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

Are services safe?

Summary of findings

Many aspects of the service were safe but some areas required improvement. There were systems to ensure clinical staff were provided with information required to deliver safe clinical care. Processes were in place to raise concerns and there was a culture of learning from incidents within the organisation. The practice assessed and monitored risks relating to the environment, and staff followed appropriate infection prevention and control practices.

The practice had a business continuity plan which detailed the arrangements for dealing with foreseeable emergencies. Staff demonstrated awareness of how to respond in a medical emergency and regular checks of resuscitation drugs were undertaken to ensure they were fit for purpose. Medicines kept on the premises were suitably stored and checked regularly to ensure they were fit for use. Staff were trained and aware of their responsibilities for safeguarding children.

Some areas of the service required improvement. There were expertise within the team for treating vulnerable patients, however staff had not received vulnerable adult training. There was no schedule of the emergency equipment kept in a portable emergency bag to ensure checks were regularly performed and, some clinical staff had not completed training in the prevention and control of infection.

Our findings

Safe patient care

The practice had arrangements in place to provide safe care. The GPs told us that safety alerts were cascaded to all GPs via email and individual GPs would action the alert. Safety alerts along with best practice guidance were discussed informally or at team meetings, however these discussions were not documented. The practice had arrangements for reporting and recording incidents and it was the responsibility of the two salaried GPs to monitor significant events.

Learning from incidents

The practice had arrangements in place for reporting and learning from significant incidents. Two of the salaried GPs were responsible for monitoring significant events and we saw evidence that staff reviewed and discussed events in team meetings. We viewed completed templates of previous significant events, which detailed the incident, action plan and learning achieved. An incident relating to a delay in diagnosis for a patient with complex co-morbidities was reviewed at a practice meeting and staff discussed if diagnosis could have been more rapid and how care could be improved.

Safeguarding

The practice lead for safeguarding was a practice nurse, who was not working on the day of our inspection. Training records confirmed that staff had undergone child protection training, with GPs trained to Level 3 and other staff trained to Level 1. The GPs met with health visitors to discuss children identified as 'at risk'. The outcomes from these discussions were inputted into the individual patient record and we saw a list of 'at risk' patients with a narrative regarding their care planning. We spoke with a GP who explained the child protection protocols undertaken by the practice and provided an example of a previous referral managed by the practice.

Another GP told us the practice would communicate and share information with the relevant Multi Agency Safeguarding Hub (MASH) if they had concerns about child protection, and that all children identified as 'at risk' were reviewed every three months by the practice.

Are services safe?

Staff had not received safeguarding vulnerable adults training, however staff we spoke with were able to describe the process of escalating a safeguarding concern when the lead was on duty and in her absence

Monitoring safety and responding to risk

The practice was monitoring and responding to risk. Following an incident relating to the abusive behaviour of a patient, the practice had placed 'zero tolerance' posters and installed CCTV in the waiting room for the safety of patients and staff. Safety information such as 'correct lifting techniques' had been displayed behind the reception desk and was visible for both patients and staff. During our visit we observed damage to a step leading to a consultation room on the ground floor. The practice had put safety tape on the step and a notice on the wall to alert patients. When we spoke to staff they informed us that an external company had reviewed the damaged step and were due to fix it the following week. We saw correspondence to confirm this.

The practice lead for health and safety had received training in 'health and safety assessment and management'. Health and safety audits, including fire risk assessments were completed each year and we reviewed completed audits for the last two years. Follow-up actions were documented and monitored by the practice lead for health and safety. In addition to the fire risk audit completed by the practice, an independent fire assessment had been undertaken by the fire service approximately 18 months ago. The practice had displayed a fire evacuation notice near the entrance of the building to inform patients of the procedures and assembly point in the event of a fire.

Medicines management

Repeat prescriptions could be ordered by dropping the reorder slip into the clinic or electronically via the practice's website. A GP partner informed us that the practice did not accept orders over the phone for safety reasons. The GPs took responsibility to issue repeat prescriptions and all the GPs we spoke with confirmed they did this. The GPs and practice manager told us this was done so that each prescription script was checked for accuracy and safety before being issued to the patient. One patient gave an example of when they required urgent medication for their health condition. The practice issued a prescription and arranged for the medication to be delivered to the patient's home the same day.

The GPs informed us that the practice recently worked with the clinical commissioning group pharmacists to review patients who were on more than 10 medicines. As a result of the review the GPs managed to reduce some of the medicines patients were taking. We saw evidence of an audit of the monitoring of immunosuppressant drugs. The audit identified actions that needed to be addressed and the practice had completed a second audit cycle to identify improvements in practice and any further action required.

The practice had systems in place for managing patients taking high-risk medicines. Prescribing for opioid dependency was undertaken via a multidisciplinary service and alerts were added to patient records so that physical health checks were undertaken when the patient attended the practice.

The medicines fridges were checked daily to ensure the temperature was within the recommended range. We saw records that these checks were completed. Medicine expiry dates were checked monthly, with records available for several years.

Cleanliness and infection control

The practice had identified two members of staff who led on cleanliness and infection prevention and control (IPC). The phlebotomist led on general cleanliness and safety of the building and environment, and a practice nurse focused on reducing the risk of healthcare acquired infections. We viewed the practice's recent infection prevention and control audit, which highlighted actions to be taken to resolve any issues. The two practice nurses had completed infection control training and provided in-house training to other staff, however the five GPs had not attended the training.

During our inspection we found the building to be clean. Hand washing instructions were clearly displayed in each clinical area we inspected. The building and non-clinical equipment was cleaned each weekday evening by an external cleaning company. We saw evidence of cleaning schedules stored within the cleaning cupboard, and these stated the daily, weekly, monthly and quarterly requirements. There was evidence of a spot-check audit against these cleaning schedules however this was not dated or signed. Staff showed us two examples of correspondence with the cleaning company regarding the spot-check audits, and these stated that one audit had been completed in May 2014 and prior to that in October 2013.

Are services safe?

Clinical equipment and furniture within the surgery and consultation rooms was cleaned during the day by reception staff using wipe clean cloths. Staff told us that specific clinical equipment such as aurascopes, stethoscopes and blood pressure cuffs were cleaned by clinical staff. We saw evidence of a rota and cleaning schedule which had been completed for several weeks prior to the inspection. We did not see evidence of an audit schedule for spot checking the cleanliness of the clinical equipment or consultation rooms to provide assurance that cleaning was completed satisfactorily.

Clinical waste disposal was outsourced to an external company and collections took place twice a week. All sharps bins had been appropriately labelled and dated. A locked store cupboard was used in the event of an overflow of clinical waste.

Staffing and recruitment

The practice had clear recruitment processes in place. We reviewed recruitment records for two GPs, one nurse and one receptionist. Application forms had been completed and contained details of the applicant's education, employment history and reasons for any gaps in employment. The practice had introduced Disclosure and Barring Service (DBS) checks for all staff and we saw these for all but one member of staff, for whom an application had been submitted. References had been obtained for all four staff, however these were not always contained within the recruitment files. Proof of identification was seen in only one file and the practice manager informed us she had seen original identification when completing the DBS application forms. We saw evidence of professional registration with the General Medical Council (GMC) for the two GPs, and registration with the Nursing and Midwifery Council (NMC) for the nurse.

The practice was in the process of recruiting an additional practice nurse to meet the demands for the service. The practice manager informed us that she met with the practice nurse on a weekly basis to monitor and reallocate the workload of the nurse vacancy. We were shown notes based on these discussions and emails to the nurse detailing the decisions management had made. The practice manager informed us that busy periods and staff shortages were responded to by ensuring enough staff were on duty or by using a locum. We noted there was a locum nurse working at the practice at the time of our visit.

Dealing with Emergencies

All staff had received basic life support training and were able to tell us the actions they would take in the event of an emergency. Emergency protocols, such as the management of anaphylaxis, were displayed within consultation rooms. Emergency drugs were located in all treatment rooms. These drugs were checked by the nurse and we saw records to confirm this. One medicine kept with the emergency drugs in one of the nurse's rooms would not be needed in an urgent situation and the practice should consider the risks of keeping it in unlocked storage. The portable emergency bag contained appropriate emergency equipment including oxygen, masks, airways and emergency drugs, all of which were functional and in date. We were told one member of staff could carry the bag and it could be transported to any part of the building in the case of an emergency. There was no schedule of what should be included within the bag and no documentation that regular checks were made to ensure equipment was in date and functioning correctly.

The clinical rooms varied in size. We found the minor surgery room on the ground floor had limited space between the treatment couch and the desk due to the layout of the room. A GP partner informed us that the layout of the room would be reviewed.

The practice had a current business continuity plan, which was comprehensive regarding the types of business failures, the potential impact on patients and alternative premises to be used in the event of catastrophic damage to the practice. Staff informed us that the practice manager and a GP partner kept a copy off-site to access the information remotely in the event of an emergency. The plan contained a detailed communication cascade flowchart, however some contact details were not up to date. A GP partner told us that staff were aware of the risks to patients if the practice was short staffed or closed.

Equipment

The practice ensured that clinical equipment was safely maintained and effective to use. We saw records of clinical equipment such as spirometers, electrocardiogram machines and minor surgery instruments had been regularly serviced, calibrated and checked for safety. These checks had been completed within the last 12 months and

two pieces of equipment which had failed the safety checks had been taken out of service. We were shown one piece of equipment which was to be disposed of, and this had a label alerting staff that the device was not to be used.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective in monitoring and improving outcomes for patients. The practice participated in clinical audits and external peer group meetings and this contributed to improvements in areas of clinical care. The practice followed National Institute for Health and Care Excellence (NICE) guidance around the treatment for patients with long term conditions such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Coronary Heart Disease (CHD).

Staff kept up to date through appraisals and on-going training. The practice worked with other practices to develop the service. Patients were given information and support regarding health promotion and prevention.

Our findings

Promoting best practice

The practice attended the Clinical Commissioning Group (CCG) led Clinical Learning Sets (CLS), where local practices met to discuss current clinical and organisational performance and issues. A GP partner attended this meeting on the afternoon of our visit. The CLS also provided local comparative data and the GPs informed us that this information was discussed with peers and clinical staff where appropriate. Two of the salaried GPs were responsible for monitoring significant events and we saw evidence that staff reviewed the National Institute for Health and Care Excellence (NICE) guidance and discussed events in team meetings.

Management, monitoring and improving outcomes for people

The practice held clinics for patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease (CHD), and followed National Institute for Health and Care Excellence (NICE) guidance for these groups of patients. We saw the CHD clinic appointment bookings which were offered with a nurse and a GP. The patient would see the nurse initially for monitoring and see the GP to discuss the results and treatment options.

The practice held childhood immunisation clinics which were led by the nursing staff. There was a system to monitor if children had received their immunisations. The practice regularly reviewed and updated a web-enabled database system which enables GP providers to enter childhood immunisation target returns online. In addition to the routine childhood immunisation schedules, the practice had run performance reports to ensure children had not been missed from campaigns such as the measles, mumps and rubella (MMR) catch-up campaign and the seasonal influenza immunisation which was extended for two-three year olds. We saw evidence of the searches run by staff to identify which children needed to be called in for a vaccination.

The practice either phoned patients with their results, or provided patients with a time to call for results. A new phone system ensured that calls were directed to the nurse rather than reception. The GPs informed us that they kept a checklist of patients they needed to see or check on once blood test results had been received.

Are services effective?

(for example, treatment is effective)

The GPs informed us that they undertook CCG-led and self-led clinical audits every year and this was used to populate their GP appraisal. The GPs were able to describe the topics audited, such as referral rates of patients, monitoring of immunosuppressant drugs and, vitamin D supplements in children aged one – four years. We reviewed two audits, completed by different GPs, which explained the conclusion of the audit and action taken as a result. An example of the action taken by the practice in the audit of the monitoring of immunosuppressant drugs included developing new template letters for patients so that there was an audit trail of advice given to the patient.

Staffing

New staff underwent an induction when commencing work. The induction included a checklist, to be completed by the staff member and their line manager, which outlined the general policies, procedures, processes, and additional sections relevant to the individual's specific job role. We saw evidence of a timetable for a new nurse to shadow clinics and clinicians so that they understood how the practice operated.

A three month probationary period was in place for new staff and we saw completed forms for staff at their three month review. This review allowed staff to discuss their progress and highlight their training needs, and we saw evidence that management had listened to this feedback and taken action. The practice had identified staff training opportunities for practice staff. A member of administrative staff had completed a health care assistant course and was developing her clinical workload. Another member of staff had been trained as a phlebotomist and offered this service to both the practice and neighbouring GP surgeries. The practice manager told us the probationary period could be extended if needed and the pro-forma we saw supported this.

Peer support and supervision for the GPs and nurses was described as informal and not documented. Staff appraisals took place annually. Staff were required to complete a self-assessment form prior to appraisal and we saw evidence of a recently completed form. Staff were appraised by the practice manager and two doctors. The practice manager and GPs confirmed that GPs underwent external appraisals and they reviewed each other's work. Four GPs had undergone their annual appraisals, and one GP was due to attend later this year. All GPs were awaiting revalidation.

Working with other services

The practice worked effectively with other services. Staff told us that the practice strategy was to link with other surgeries in the area to deliver local services to patients. The practice had implemented a phlebotomy service which was provided to their own patients, as well as for patients of neighbouring practices. Discussions had also taken place with local surgeries during the pandemic flu outbreak. The practice and other GPs in the area agreed a joint approach in keeping services open and providing access to services remotely in the event of an emergency.

The practice held monthly multidisciplinary meetings with the community matron, social workers and colleagues from local palliative care services to discuss the most vulnerable patients. The practice also worked with a multidisciplinary team to support a local home for patients with learning disabilities. The practice was due to install a new IT system, which one GP told us would allow staff to access all the multidisciplinary team notes for a patient.

The practice referred patients to a range of specialist services within the local area. A GP told us the practice used advice helplines for information on key specialities. Another GP informed us that the "Choose and Book" system was used for referrals, and that urgent referrals which met the two-week wait criteria were processed immediately.

Health, promotion and prevention

The practice promoted patients'' health and well-being. Health promotion information was available for patients in the reception area. It included leaflets on various health conditions, screening services, immunisations and a variety of support services for patients and their families or carers. Staff told us there was a checklist for new patients registered with the practice, and this included arranging an initial appointment with the health care assistant to discuss their medical history, medications and any concerns. During this appointment the patient's height, weight, blood pressure and urine test were checked. Lifestyle was also discussed and if concerns were identified then the patient would be referred to the nurse for further consultation. The practice also offered a smoking cessation group which was run by the health care assistant.

There was a blood pressure machine in the waiting room. Patients were encouraged to take their blood pressure before seeing the doctor, and instructions on how to use the machine and print results were provided.

Are services caring?

Summary of findings

Many aspects of the service were caring but some areas required improvement. All the patients we spoke with, and the comments we received were complimentary of the care and service that staff provided. Patients used the NHS Choices website to provide feedback and results from the GP survey were overall positive, with most patients stating they felt listened to by the GP. Many patients felt staff supported them to make choices and decisions for themselves. We found patient's care was planned and delivered in a way that met their individual needs.

An area we identified as requiring improvement related to patient's privacy and dignity. The practice did not have privacy screens in most consultation rooms and, curtains or blinds were not present in one consulting room to respect patients' privacy and dignity during consultations.

Our findings

Respect, dignity, compassion and empathy

We observed reception staff greeted patients in a polite and friendly manner. All the patients we spoke with described the service as caring. The practice's own survey found that most patients rated their experience with the doctors and nurses as very good. In the NHS England GP patient survey 2014, 85% of respondents said the last GP they saw or spoke to was good at treating them with care and concern.

The practice had a chaperone service available for patients wishing to have someone of the same gender present during examinations. This information was displayed in the waiting room for patients to view. Some patients recalled being asked if they would like a chaperone during examinations.

The practice did not always respect patients' privacy and dignity. One clinical room on the ground floor did not have curtains or blinds on the window. Most clinical rooms did not have privacy curtains or screens around the examination couch. We spoke to staff regarding this and were informed that the previous screens had been removed in March 2014 and the practice was in the process of looking into screening options. During this interim period the practice used 'do not disturb' notices on the outside of the door to alert staff and patients not to enter the room.

Involvement in decisions and consent

Patients who used the service understood the care and treatment choices available to them. A GP informed us that email was used to send patients further information on treatments, and this was confirmed by one patient that we spoke with. Most patients told us that the doctors always discussed the options with them before treatment began. In the NHS England GP patient survey 2014, 82% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care and 83% of respondents said the last nurse they saw or spoke to was good at listening to them.

The practice looked after patients with learning disabilities from a local care home. The GPs were aware they may need to assess mental capacity when treating patients with

Are services caring?

learning disabilities. The care home manager told us the doctors' approach and communication with patients was very good, and although one GP had been allocated to each patient, the patients had a choice to see any GP.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Patients' needs were appropriately assessed and met. This included patients with long term conditions. Some staff had expertise in treating homeless patients and the practice offered a specialist service to a learning disability home and women's refuge.

The practice offered weekday walk-in clinics and pre-booked appointments, and the premises was accessible to patients with mobility difficulties. Patients told us they found it easy to access the service. The practice had listened to feedback from the recent practice survey and Patient Representative Group, and made changes to improve the service. Information about the complaints process was available for patients and the practice had learned from patients' experiences, concerns and complaints to improve the quality of care.

Our findings

Responding to and meeting people's needs

Patients told us their health care needs were met. There were systems in place to support patients with long term medical conditions, including diabetes, coronary heart disease (CHD) and chronic kidney disease. A poster informing patients of when to fast for certain blood tests was displayed in the waiting room.

Provisions had been made to ensure patients with mobility needs could access the service. The practice was based in a converted house and operated over several floors. A ramp, handrails and electronic push button for the front door were installed outside the property to assist patients when entering the building. A stair lift had been installed between different levels on the ground floor providing access to clinical rooms on this level, including a minor surgery room. The practice had labelled chairs in the reception area as 'priority seating' for patients with mobility needs, following feedback from the patient representative group.

The practice had access to interpreting services over the telephone to meet the needs of patients who did not speak English as their first language. A poster providing information about the interpreting service had been displayed in the reception room and was written in English. This meant patients who would benefit from the service may not be able to access the information easily. The practice informed us that some staff spoke other languages and patients usually brought a family member who could interpret for them.

The practice looked after patients with learning disabilities from a local care home. The care home manager confirmed that five patients of the home were registered with the practice and all had recently had their health action plan and health checks undertaken at the practice.

The practice had developed expertise in caring for homeless patients, and received support from the community psychiatric nurse and consultant psychiatrists during multidisciplinary meetings. Some GPs had special expertise in the medical care of homeless patients as they also worked at a drop in surgery for homeless patients. Services were also provided to a women's refuge centre in the local area.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients found the service easy to access. The practice was not a walk-in centre, however they offered two walk-in clinics on Monday, Tuesday, Thursday and Friday, and one walk-in clinic on Wednesday. Patients could attend the morning or afternoon walk-in clinics without an appointment. Late evening appointments were available for four days per week. Booked appointments slots were available every weekday but could only be booked over the phone as the practice's website did not contain an online booking system. The opening hours were displayed on the front door of the building, in the waiting room and on the practice's website.

During the walk-in clinics we observed that patients were able to choose which GP they saw and staff treated patients in a respectful manner. Patients we spoke with found the service was easy to access and described the walk-in clinics as excellent. We spoke with patients regarding seeing a doctor for urgent appointments, and many patients told us this was not a problem as the walk-in clinics accommodated this. The practice did not provide a service out-of-hours, however information was available to patients in the waiting room on who to contact if they had a medical concern out-of-hours.

Concerns and complaints

The practice had a system in place to support patients using the complaints system, and it was the responsibility of the practice manager and a GP partner to review all complaints. The practice's complaints and comments procedure provided guidance on how to make a complaint, whom to speak to within the practice, and external organisations where complaints could be raised. A 'complaints and comments leaflet' and a comments box were on display in the reception area. There was also information informing patients on how to join the practice's virtual Patient Representative Group (PRG), who would contact them for their views and opinions. Patients we spoke with had not made a complaint but said they would speak with staff if they needed to.

The practice manager completed an annual review of all complaints, and we reviewed the complaints register which provided a detailed analysis of each complaint and an audit trail of activities undertaken to resolve the complaint. All the complaints we reviewed had been responded to and a solution offered where appropriate. The practice had also documented learning that had occurred as a result of the complaint. The learning from a complaint received regarding a locum nurse was to ensure practice staff encouraged patients to provide feedback when they saw a locum member of staff. Complaints were discussed in practice meetings if appropriate, and we saw meeting minutes to confirm this had occurred.

Are services well-led?

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

Summary of findings

Governance arrangements were in place with identified leads for specific areas and support for staff to develop their roles in order to improve patient care. Staff described a positive culture of openness and support within the practice. The practice were involved in the Patient Representation Group and learned from patients' experiences, concerns, and complaints to improve the quality of care. The practice had systems in place to identify risk, such as health and safety assessments and a business continuity plan.

Our findings

Leadership and culture

The practice was managed by two GP partners and a practice manager, and there was strong leadership from both GP partners. One partner described the practice's emphasis as helping patients who were discharged from hospital and developing integration with other services. The practice manager was aware of the need to manage developing issues and provide leadership for staff. Both clinical and administrative staff were aware of the management structure in place, and described a positive culture of openness and support within the service. Staff also told us that the practice aimed to provide high quality care for all and that the surgery was open to feedback from patients.

Governance arrangements

Staff roles and responsibilities were clear as the practice had identified leads for different areas such as infection control, health and safety, safeguarding, significant events and information governance. Staff demonstrated a good understanding of their area of responsibility and tried to ensure high standards of service were maintained. Issues and shared learning were discussed at staff meetings and we saw minutes to confirm this.

Systems to monitor and improve quality and improvement

GPs we spoke with described their involvement in clinical audits led by the Clinical Commissioning Group and for their GP appraisals. A GP partner expressed that the practice would like to expand their role in conducting clinical audits. The practice was monitoring and improving the quality of service through its work with the Patient Representative Group (PRG), investigation of complaints and analysis of significant events.

Patient experience and involvement

The practice had an active Patient Representative Group (PRG) which comprised of 13 members who represented the diverse needs of the practice population. All members were patients, with the exception of one person who was the representative for five patients from a local learning disability home. Other members of the group included a patient from the local women's shelter, a pregnant patient, a patient with a physical disability, patients with long-term conditions, a patient with mental health problems, and a mother with two young children.

Are services well-led?

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

The group was led by one of the salaried GPs. Before and during our visit we spoke with three PRG members, who told us that the meetings were well organised and that ample time was spent addressing patients' concerns and the results of surveys. A recent survey conducted over a five month period had received 151 completed surveys, which were analysed by the GP in February 2014. The results showed that most patients were happy with the service and that it met their needs, and we found this was the case when speaking with patients about their care and treatment. The practice had attempted to address issues identified, and if a problem could not be addressed the practice had explained the reasons why. Examples of improvements made to the waiting room included installing blinds, providing a magazine rack and displaying only essential information on the walls. The practice made the survey results and action plan available to patients by displaying them in the waiting room of the practice and on their website.

Staff engagement and involvement

The practice had a stable team with many of the staff employed for a number of years. Peer support and supervision for the GPs and nurses was described as informal and not documented. A GP partner informed us that electronic support was available by way of emails cascading clinical updates and educational support to staff. Clinical staff told us they were encouraged to seek advice and feedback from colleagues through an open door policy. The practice manager informed us that she had regular meetings with staff to ensure they were supported in their role, however these meetings were informal and not documented. Staff confirmed they did not receive formal supervision but could talk with the practice manager if required.

Practice meetings between staff and management were held every two months. We were shown agendas, attendance lists and minutes to these meetings. The meetings offered staff an opportunity to discuss their views. The practice had a whistleblowing policy in place for staff to access if they had concerns about the practice.

Learning and improvement

The practice manager informed us that appraisals took place annually. Staff confirmed these procedures and said they found the appraisal process supportive. Practice management and administration staff told us that the practice was proactive in supporting their development and encouraged staff to receive training and develop their roles within the practice. This was demonstrated by two receptionists who had received training to perform their new roles as a health care assistant and a phlebotomist.

Identification and management of risk

The practice had systems in place to identify risk, such as health and safety assessments and a business continuity plan. A recent risk identified was preparing for the installation of a new IT system. The practice had taken action to inform patients and minimise potential disruption to the service. Information was displayed on the front door, in the waiting room, and on the practices website informing patients of the specific dates affected by the installation of the IT system.

Clinical meetings were informal and occurred on an ad-hoc basis. Staff told us that if they had clinical concerns they would discuss these immediately with colleagues rather than waiting for a scheduled meeting. A GP informed us of an incident when the phlebotomist had been overbooked. The practice had taken action to prevent such an incident reoccurring by lengthening the time available for blood tests and arranging an extra collection of blood samples later in the day

Older people

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

Summary of findings

The practice had some services to support and review older patients, such as the seasonal flu clinic and home visits. Patients over the age of 75 had a named GP.

Our findings

There were fewer older patients registered with the practice when compared with other population groups. All patients over the age of 75 had a named GP. The practice provided support to a retirement home in the local area. Seasonal flu clinics were conducted with appointments prioritised for older patients. Home visits were offered to patients who could not attend the practice, and one patient told us that the GP spoke with her elderly father over the telephone and visited her father the same day.

People with long term conditions

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

Summary of findings

The practice responded to the needs of patients with long term conditions, and followed national guidance for the treatment for these groups of patients. Care was tailored to patients' needs and the practice had a multi-disciplinary approach. The practice's Patient Representative Group (PRG) included patients with long term conditions.

Our findings

There were systems in place to support patients with long term medical conditions. The practice held clinics for patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease (CKD) and coronary heart disease (CHD), and followed the National Institute for Health and Care Excellence (NICE) guidance for the treatment for these groups of patients.

We saw clinic appointment bookings where patients initially saw the nurse for monitoring and then the GP to discuss the results and treatment options. A poster informing patients of when to fast for blood tests for conditions such as diabetes and CKD, was on display in the waiting room.

The practice held monthly multidisciplinary meetings with the community matron, social workers and colleagues from local palliative care services to discuss the most vulnerable patients.

The practice Patient Representative Group (PRG) included patients with long term conditions, to represent this population group.

Mothers, babies, children and young people

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

Summary of findings

The practice responded to the needs of babies and children. The practice held childhood immunisation clinics and protocols were in place to identify which children needed to be called in for vaccinations. GPs met with health visitors to discuss children identified as 'at risk'. The practice's Patient Representative Group (PRG) represented pregnant patients and mothers with children. The practice had some services to support young people. New patients aged 16-25 years were routinely offered chlamydia screening during their new patient health check

Our findings

There was a lead for child protection within the practice and all staff had received the recommended level of training. The practice held antenatal clinics which were led by the GPs and childhood immunisation clinics which were led by the nursing staff. Protected appointment slots were available to ensure patients were seen, and if a child did not attend an appointment they were contacted by the practice staff. The nursing staff had access to three separate systems for checking which children were due for immunisations and for inputting immunisation data on a regular basis. All three systems could be cross-checked against each other to ensure that a child was not missed for immunisation. The practice also had a policy in place to ensure newly registered children attended an appointment with their parent/guardian, so that the nurse could check their immunisation status. Missing immunisations would then be discussed and offered to the child following parental discussion and consent. In addition to the routine childhood immunisation schedules, the practice had run reports to ensure children had not been missed from campaigns such as the Measles, Mumps and Rubella (MMR) catch-up campaign and the seasonal influenza immunisation which was extended for two-three year olds. We saw evidence of the searches run by staff to identify which children needed to be called in for a vaccination.

The GPs met with health visitors to discuss children identified as 'at risk'. The outcomes from these discussions were inputted into the individual patient record and we saw a list of 'at risk' patients with a narrative regarding their care planning.

The practice had protocols in place for chlamydia screening. All new patients aged 16-25 years were offered chlamydia screening during their new patient health check. Other tests for sexually transmitted infections were conducted during routine appointments.

Mothers, babies, children and young people

Health promotion information was available to patients in the reception area and included leaflets on various health conditions and vaccination schedules for children.

The practice Patient Representative Group (PRG) included a pregnant patient and a mother with two young children, to represent this population group.

Working age people (and those recently retired)

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

Summary of findings

The practice responded to the needs of the working-age population by offering flexible access to appointments, and online facilities for requesting repeat prescriptions, registering with the practice and providing feedback. New patients aged 16-25 years were offered chlamydia screening during their new patient health assessment.

Our findings

The population demographics for the area included a higher proportion of 20-39 year olds, and this was reflected in the practice list with the majority of patients aged 25-45.

The practice had new protocols in place for chlamydia screening. All new patients aged 16-25 years would be offered chlamydia screening during their new patient health assessment.

The walk-in clinics provided good access for patients to see a GP or nurse and telephone consultations were available on request. The practice operated extended opening hours to 8pm on four evenings a week, and it was possible to book appointments several weeks in advance. A few patients had made comments on the recent patient survey requesting early morning appointments due to work commitments. The practice had extended opening hours by appointment on Wednesday mornings from 8am for patients to see a GP, and the phlebotomist saw patients daily from 7.50am.

The practice also offered online facilities for patients to request repeat prescriptions, register with the practice and provide feedback.

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

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

Summary of findings

The practice supported patients in vulnerable circumstances. The practice supported patients from a local learning disability home and a women's shelter. The practice had developed expertise in caring for homeless patients, with community psychiatric support available and extended health checks offered to homeless patients. The practice conducted a drug dependency clinic and received multi-disciplinary input. The practice's Patient Representative Group (PRG) represented patients in vulnerable circumstances.

Our findings

The practice worked with a multidisciplinary team to support a local care home for patients with learning disabilities. The GPs were aware they may need to assess capacity when treating patients with learning disabilities. The care home manager confirmed that five patients of the home were registered with the practice and all had recently had their health action plan and health checks undertaken at the practice. The care home manager told us the doctors' approach and communication with patients was very good, and although one GP had been allocated to each patient, the patients had a choice to see any GP. Information was available to patients in the reception area and included leaflets on support services for patients and their families or carers. The practice Patient Representative Group (PRG) included a care home manager who represented five patients from a local learning disability home.

There were 55 homeless patients registered with the practice. The practice had developed expertise in caring for homeless patients and received support from the community psychiatric nurse and consultant psychiatrists during multidisciplinary meetings. Homeless patients were offered an extended registration health check which included screening for blood borne viruses and vaccinations. Referral to other services such as mental health and drug and alcohol services were available if required. Some GPs had greater expertise in the medical care of homeless patients as they also worked at a drop in surgery for homeless patients. Services were also provided to a refuge for young women who were homeless. The PRG included a woman from the shelter to represent this population group.

The practice conducted drug dependency clinics and prescribing for opioid dependency was undertaken via a

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

multidisciplinary service. Alerts were added to patient records so that physical checks were undertaken when the patient attended the practice. Information on drug and alcohol support services was available to patients in the reception.

People experiencing poor mental health

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

Summary of findings

The practice had some services to support and review patients with mental health problems, such as multi-disciplinary input and representation at the practice's Patient Representative Group (PRG).

Our findings

The practice received support from the community psychiatric nurse and consultant psychiatrists during multidisciplinary meetings. The practice Patient Representative Group (PRG) included a patient with mental health problems, to represent this population group

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. How the regulation was not being met: The registered person did not make suitable arrangements to ensure the dignity and privacy of service users. Regulation 17(1)(a)

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. How the regulation was not being met: The registered person did not make suitable arrangements to ensure the dignity and privacy of service users. Regulation 17(1)(a)

Regulated activity	Regulation
Family planning services	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. How the regulation was not being met: The registered person did not make suitable arrangements to ensure the dignity and privacy of service users. Regulation 17(1)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. How the regulation was not being met: The registered person did not make suitable arrangements to ensure the dignity and privacy of service users. Regulation 17(1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. How the regulation was not being met: The registered person did not make suitable arrangements to ensure the dignity and privacy of service users. Regulation 17(1)(a)