The Portland Road Practice

Quality Report

16 Portland Road
London
W11 4LA
Tel: 0207 727 7711
Website: http://www.portlandroadsurgery.nhs.uk/

Date of inspection visit: 14 May 2014
Date of publication: 24/09/2014

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

Contents

Summary of findings

Overall summary

The Portland Road Practice is a GP surgery which provides a primary medical service to patients in the Notting Hill, Kensington and Shepherds Bush areas within the Royal Borough of Kensington and Chelsea. The practice currently has about 7500 patients on its list. The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures; maternity and midwifery services; surgical procedures; and treatment of disease, disorder or injury

We carried out an announced inspection of the service on 14 May 2014. The team, led by a CQC inspector, included a GP, a practice manager specialist advisor and an expert by experience.

We spoke with seven patients and received comments cards from six others during our inspection. All but one made positive comments about The Portland Road Practice and the service provided. They were generally happy they could get an urgent appointment but some patients expressed their dissatisfaction with the long wait for routine appointments.

The service to all population groups was generally effective, caring and responsive. The practice was effective in promoting best practice and had arrangements in place to monitor, review, and improve outcomes for people. Patients told us staff were caring and treated them with dignity and respect. The practice understood the needs of its patients and was responsive to them. There was good collaborative working between the provider and other health and social care services. However, there was scope for improvement in the waiting times for non-urgent appointments and in ensuring patient confidentiality.

There were inadequate arrangements in place to ensure the service was safe:

- The infection control arrangements in place did not fully protect patients from the risk of infection. The standards of cleanliness were inadequate and the arrangements to maintain appropriate standards of hand hygiene were not sufficiently robust. We found dust in a number of areas and a lack of general cleanliness in other areas. The practice had a cleaning schedule but the checklist for this was had not been completed since October 2013 and did not cover all areas. The regulations were not being met in relation to cleanliness and infection control.
- There were a number of potential risks relating to safety of the premises. One of the consulting rooms on the first floor had a back door which was unlocked and had no signage that the room was in use. The door opened outwards onto the stairway and there was no signage warning of this, which could put anybody passing on the stairs at risk. There was no regular testing of the fire alarm system between annual checks and no fire evacuation drills had taken place. There was no up to date record of portable appliance testing and no evidence of gas boiler servicing. The regulations were not being met in relation to safety and suitability of premises.
- There was not a robust recruitment policy and procedure in place. We saw no evidence of identity checks before recruitment. On records we looked at there was only one reference for one member of staff and no references for another. For non-clinical staff there was no documented risk assessment of which staff needed to be subject to a criminal record check. We were told the need for checks had been considered but limited progress had been made in following this up at the time of the inspection. The regulations were not being met in relation to requirements for workers.
- Patients records were not always kept securely. There was an unlocked filing cabinet in the cleaner's cupboard, which was accessible to unauthorised people and contained identifiable patient records and x-rays in torn plastic bin liners. The computer server room was unlocked and some patient records were stored in the room. We observed one consulting room left unattended with the door open while the GP saw a patient downstairs. The computer was on and the security smart card was left on the desk. The regulations were not being met in relation to security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led. Communication within the practice on

Summary of findings

management and operational issues was not as effective as it could be. It was not clear how lessons learned from incidents were communicated to staff or how identified areas for improvement had been followed up to ensure lessons learned were implemented. It was not clear how recommended controls identified from the practice's health and safety risk assessment were communicated within the practice and followed up and implemented. In addition, the systems in place to identify, assess and manage other risks to the health, safety and welfare of people who use the service and others were not effective. The regulations were not being met in relation to assessing and monitoring the quality of service provision.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was not safe and improvements were needed.

The provider reviewed incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were appropriate arrangements for the management of medicines. There were effective arrangements in place and equipment available to deal with medical and other emergencies.

However, there were unsuitable arrangements in place to ensure the service was always safe. Improvements were needed in a number of areas to ensure patients were fully protected against the risks of unsafe care and treatment.

Patients were not sufficiently protected from the risk of infection. Improvements were required in the operation of infection control systems and in the standards of cleanliness and hygiene in relation to premises and equipment.

Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. We found a number of potential risks relating to the safety of the premises in areas patients had access to.

Patients were not fully protected against all the risks associated with the recruitment of staff. This was because there was insufficient evidence that all appropriate pre-employment and checks had been carried out for staff.

People were not always protected from the risks of unsafe or inappropriate care and treatment because records were not always kept securely.

Are services effective?

The practice was effective in promoting best practice and had arrangements in place to monitor, review, and improve outcomes for people. This was done through internal scrutiny and externally through peer review and participation in local initiatives.

There were arrangements in place to support staff. This included: staff appraisal, learning and professional development opportunities.

Summary of findings

The provider worked in collaboration with other health and social care professionals to support particular patient groups. This included mothers and children, older patients, patients with learning difficulties, patients with drug and alcohol problems and homeless people.

The provider promoted good health and prevention. Patients received advice and guidance about making healthy life style choices and were referred to health and well-being schemes.

Are services caring?

Feedback from patients during the inspection was mostly positive about the services they received. They indicated that staff were caring and treated them with dignity and respect. We observed patients being dealt with in a friendly and courteous manner.

The provider delivered a mostly caring service. However there was scope for improvement in ensuring patients' privacy and dignity during telephone calls and their attendance at the practice.

We found patients were involved in decisions about their care. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with legal requirements.

Are services responsive to people's needs?

We found that the practice understood the needs of its patients and was responsive to them. There were arrangements in place so patients whose first language was not English could access the service and communicate their needs.

There was good collaborative working between the provider and other health and social care services which helped to ensure patients' needs were met. The practice took part in local schemes and projects to provide enhanced services.

The provider engaged with patients to gather feedback on the quality of the service provided and acted on this in order to improve the service.

Some patients were dissatisfied with telephone access to the practice and the availability of routine appointments. The practice had taken steps to improve accessibility but this was under further review.

Summary of findings

Are services well-led?

The leadership, management and governance arrangements did not ensure the service was sufficiently well led.

The practice had stated aims and a mission statement. The governance arrangements included systems to monitor the quality of service, manage risks and learn from incidents. The practice also sought to involve patients and staff to improve service delivery.

However, communication in the practice on management and operational issues was not as effective as it could be. It was not clear that the practice's vision and values had been communicated to staff. The record of practice meetings was not shared with staff and was not up to date. Practice policies and procedures were not systematically reviewed and changes communicated to staff. Staff did not always know who the named leads were for specific areas. It was not clear how lessons learned from incidents were communicated to staff or how identified areas for improvement had been followed up to ensure lessons learned were implemented. It was not clear how recommended controls identified from the practice's health and safety risk assessment were communicated within the practice and followed up and implemented. In addition, the systems in place to identify, assess and manage other risks to the health, safety and welfare of people who use the service and others were not effective.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to older people was generally effective, caring and responsive. There were effective arrangements in place to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned to meet identified needs of patients over age 75 and was reviewed. There was evidence of arrangements in place and engagement with other health and social care providers. For example, a primary care navigator from Age UK had recently started working with the practice as part of a project to support older people in gaining access to NHS services. Patients were referred to health and wellbeing schemes.

There were appropriate and effective end of life care arrangements in place. The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups which also covered older people. The Practice was also part of a Dementia Direct Enhanced Services (DES) scheme to identify who would benefit from screening. Home visits were carried out by the duty GP for those who were not well enough to attend the surgery.

People with long-term conditions

The arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to people with long term conditions was generally effective, caring and responsive. There were safe arrangements in place to manage repeat prescriptions for people with long term

Summary of findings

conditions. The provider had effective arrangements in place to help patients manage their long term conditions. The practice took part in regular clinical learning set (CLS) audits relating to long term conditions, for example diabetes and musculoskeletal conditions.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups with long term conditions.

Mothers, babies, children and young people

The arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to mothers, babies, children and young people was generally effective, caring and responsive. There were effective arrangements in place to safeguard children and young people. There were arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people.

The working-age population and those recently retired

The arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to working age people (and those recently retired) was generally effective, caring and responsive. Patients were asked for their consent to treatment and felt involved is decisions about their care. Patients received advice and guidance about making healthy life style choices. The provider had effective processes in place for the referral of patients to secondary care. Evening clinics were available for those patients who could not get to the surgery during regular working hours.

Summary of findings

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

The arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The arrangements in place for the general population also sought to ensure treatment was effective, caring and responsive for people in vulnerable circumstances who may have poor access to primary care. There were effective arrangements in place to identify vulnerable people at risk of abuse. Patients who spoke a different language had access to an interpretation service. There was a system for assessing the support needs of carers. The practice was signed up to a Directed Enhanced Service (DES) scheme to provide annual health checks for patients with learning disabilities.

People experiencing poor mental health

The arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The arrangements in place for the general population also sought to ensure treatment was effective, caring and responsive for people experiencing poor mental health. However, during the inspection we did not review specific evidence in these areas relating to patients within this population group.

Summary of findings

What people who use the service say

The majority of patients we spoke with and received comments cards from during our inspection made positive comments about The Portland Road Practice and the service provided. Patients who used the practice told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect. They were complimentary about the caring, helpful attitude of both the clinical and non-clinical staff. However, one person we spoke with was unhappy about their treatment by the reception staff and told us they would be making a complaint.

Some of the patients we spoke with raised the difficulty they had in getting through to the practice by telephone to get an appointment. They were generally happy they could get an urgent appointment but some patients expressed their dissatisfaction with the long wait for non-urgent appointments.

We reviewed the local patient participation (2013-2014) annual report, which included an analysis of a patient survey conducted with input from the patient participation group (PPG). We noted that of the 120 patients who responded, 84% would recommend the surgery to anyone else. The report included an action plan for 2013-14 in response to the issues discussed by the PPG. Action included increasing the level of communication with patients, especially around access to services and A&E attendance. There was also an action plan from the November 2013 PPG which included the creation of an email group to facilitate more spontaneous feedback; a review of booked appointments compared to a walk-in system; and the update of the practice leaflet to include better information about the use of services. We were told by the practice manager both action plans had yet to be fully implemented but were planned for completion in 2014-15.

Areas for improvement

Action the service MUST take to improve

The arrangements in place to ensure the service was safe were not adequate. Improvements were needed in a number of areas to ensure patients were fully protected against risk:

- Patients were not sufficiently protected from the risk of infection because infection control arrangements in place and standards of cleanliness id not fully protect patients from the risk of infection. (Regulation 12(1) and (2)(c)(i)and(ii))
- Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. (Regulation 15(1)(a),(b) and (c)(i))
- Patients were not fully protected against all the risks associated with the recruitment of staff because the recording of recruitment information was limited and not all appropriate pre-employment checks had been carried out or recorded. (Regulation 21(a) and (b))
- Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because records about them were not always kept securely. (Regulation 20(2)(a))

The leadership, management and governance arrangements did not ensure the service was sufficiently well led:

- The provider did not have an effective system in place to assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. (Regulation 10 (1)(a) and(b))

Action the service COULD take to improve

The practice's child protection protocol contained no details for contacting the Care Quality Commission. Not all staff knew who the practice safeguarding lead was.

The keys were left in both of the practice's vaccine fridges and during the inspection the room where one of the fridges was located was left unattended with the door open, meaning the vaccines were not secure.

Patients were generally happy they could get an urgent appointment but felt the wait for non-urgent appointments was too long.

Summary of findings

Patient confidentiality was not always sufficiently ensured during telephone conversations with reception and attendance at the practice.

In responding to written complaints the practice did not as a matter of course provide specific information about the external second stage of the complaints procedure.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was taking part in a dementia research project, for which patients at the practice had volunteered.

The Portland Road Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP and the team included a practice manager specialist advisor and an expert by experience. The GP, practice manager specialist advisor and expert by experience were granted the same authority to enter The Portland Road Practice as CQC inspectors.

Background to The Portland Road Practice

The Portland Road Practice is a single location surgery which provides a primary medical service to approximately 7,500 patients in the Notting Hill, Kensington and Shepherds Bush areas of West London. The population groups served by the practice included a cross-section of socio-economic and ethnic groups. A high proportion of patients were aged over 65. There were also a large number of children cared for at the practice under the age of five.

At the time of our inspection, there were three GP partners and a practice manager partner at The Portland Road Practice. The practice also employed three salaried GPs, a practice nurse, a health care assistant and six administrative staff.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. 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?

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

- Vulnerable older people (over 75s)
- People with long term conditions
- 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 visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We liaised with the West London Clinical Commissioning Group (CCG), NHS England and Healthwatch.

Detailed findings

During our visit, which took place over one day on 14 May 2014, we spoke with two salaried GPs, a principal GP partner, the practice manager, the practice nurse and administrative staff. We spoke with five patients and two members of the practice's patient participation group (PPG). Six patients completed comments cards telling us what they thought of the care they have received from the service.

We observed how patients were being cared for and talked with carers and/or family members and spoke on the telephone with two members of the patient participation group (PPG). We reviewed information that had been provided to us during the visit and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, audits and risk assessments and related action plans, staff records and health information and advice leaflets.

Are services safe?

Summary of findings

The service was not safe and improvements were needed.

The provider reviewed incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were appropriate arrangements for the management of medicines. There were effective arrangements in place and equipment available to deal with medical and other emergencies.

However, there were unsuitable arrangements in place to ensure the service was always safe. Improvements were needed in a number of areas to ensure patients were fully protected against the risks of unsafe care and treatment.

Patients were not sufficiently protected from the risk of infection. Improvements were required in the operation of infection control systems and in the standards of cleanliness and hygiene in relation to premises and equipment.

Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. We found a number of potential risks relating to the safety of the premises in areas patients had access to.

Patients were not fully protected against all the risks associated with the recruitment of staff. This was because there was insufficient evidence that all appropriate pre-employment and checks had been carried out for staff.

People were not always protected from the risks of unsafe or inappropriate care and treatment because records were not always kept securely.

Our findings

Safe Patient Care

The patients we spoke with trusted the GPs and nurses and raised no concerns about their safety at the practice.

The practice had a number of policies and procedures in place to ensure safe patient care, such as health and safety, infection control and dealing with significant events. However, we found the policies and procedures were not implemented as effectively as they could be to protect patients from the associated risks.

We found a number of potential risks relating to safety of the premises. One of the consulting rooms on the first floor had a back door which was unlocked and had no signage that the room was in use. The door opened outwards onto the stairway and there was no signage warning of this, which could put anybody passing on the stairs at risk. The provider had a number of arrangements in place for monitoring safety and responding to risk related to the operation of the premises. However, these arrangements did not always protect patients and staff from risk. There was a fire alarm system and records showed this was serviced annually. However, there was no regular testing of the alarm system between the annual checks and no fire evacuation drills had taken place. Staff received training in fire safety and the practice had a named fire marshal, although there was no named deputy to cover for absences. There was no up to date record of portable appliance testing (PAT) and no evidence of gas boiler servicing.

Patients records were not always kept securely. There was an unlocked filing cabinet in the cleaner's cupboard, which was accessible to unauthorised people and contained identifiable patient records and x-rays in torn plastic bin liners. The computer server room was unlocked and some patient records were stored in the room. We observed one consulting room left unattended with the door open while the GP saw a patient downstairs. The computer was on and the security smart card was left on the desk.

Learning from Incidents

There were systems in place to report and learn from incidents. This included a form for recording and reporting the investigation of the incident. Incidents were also reported to the CCG for monitoring purposes. We were told incidents and events were discussed at weekly clinical

meetings held at the practice and we saw these were included in of the log of these meetings. However, it was not clear how lessons learned from incidents were communicated to staff as the meetings log was not shared with staff and only brief details were recorded. In addition, it was not always evident from the log how identified areas for improvement had been followed up to ensure lessons learned were implemented. For example, we heard of one incident where a patient had been given a blood test in error but saw no evidence of any documented change in practice to avoid a recurrence.

Safeguarding

The practice had a child protection policy and a vulnerable adult's policy. These included contact details for other relevant agencies and organisations, however the child protection policy contained no details for contacting the Care Quality Commission. There was a named GP lead for safeguarding children but not vulnerable adults and not all staff we spoke with knew who the practice safeguarding lead was.

Staff we spoke with understood how to recognise signs of abuse and the process to follow if they had concerns. The majority of non-clinical staff had completed level 1 safeguarding training and this was planned for one, more recently recruited, member of the administration staff. Clinical staff had completed safeguarding training (GPs level 3 and nursing staff level 2). Some staff were due for refresher training in child protection and all GPs in safeguarding of vulnerable adults.

Medicines Management

The practice had a medications policy and procedure in accordance with the requirements of the local Clinical Commissioning Group (CCG). We also saw the practice's repeat prescription policy and medicines reconciliation protocol. Daily checks were carried out and records were kept of fridge temperatures where vaccines were stored. We carried out a random check of vaccines and found they were in date. However, the keys were left in both vaccine fridges and during the inspection the room where one of the fridges was located was left unattended with the door open, meaning the vaccines were not secure.

The practice nurse carried out a weekly check of drugs in the practice's two emergency resuscitation kits. The records of the checks simply noted that a check had been carried out and the date. The type of medication, the quantity and the expiry date was not recorded. No check was made of medication in doctors' bags which were used for home visits but doctors were responsible for stocking their own bags. We checked the drugs in the practice's two emergency kits. In both, the drugs were in date.

Prescribing activity by the practice's GPs was monitored by the CCG's medication management team (MMT). The practice had agreed with the MMT a list of medications to review with the aim of reducing unnecessary prescribing. Performance was reviewed monthly at practice meetings as well as regular discussion at local clinical learning set (CLS) meetings and the practice was benchmarked against other GP practices. The practice was also participating in a CCG-led project examining patients prescribed 10 or more medications and whether the prescriptions were still safe and appropriate. The practice received action points from the MMT which the practice's prescribing lead followed up, inviting the patient to attend a clinic for a medication review.

Cleanliness & Infection Control

The practice had a cleaning contract, an infection control policy, named staff responsible for infection control, the provision of personal protective equipment and a waste management contract. The majority of staff had been trained in infection control and had completed recent refresher training; doctors were due to complete this training shortly. However, we found the infection control arrangements in place did not fully protect patients from the risk of infection. The arrangements to maintain appropriate standards of hand hygiene were not sufficiently robust. In both clinical and non-clinical areas hand gel dispensers were empty and only non-antibacterial soap dispensers were available. In one of the staff toilets there were no paper towels. Many of the waste bins in use in the practice were not foot or hand sensor operated to avoid recontamination of hands after washing.

The standards of cleanliness were inadequate. The practice had commissioned an infection control audit by an external organisation in April 2014. The audit had recommended a deep clean of the practice as many areas were cluttered and dusty. We were told that this had been implemented but we found dust in a number of areas including on chairs, examination couches and the emergency oxygen cylinder. A glass trolley in one treatment room was not clean and a ceiling air extractor vent in another room was coated with dirt. The practice had a

Are services safe?

cleaning schedule but the checklist for this was last signed on 22 October 2013 and did not cover all areas. For example, it did not include the cleaning of children's toys, facilities in the baby changing room or blinds.

Staffing & Recruitment

There was no formal process of workforce planning to match staffing levels and skill mix to patient needs. We were told that if there were sudden changes in demand, the practice would prioritise appointments according to need and would not turn anybody away. The practice used a recruitment agency to provide locum doctor cover during absences of the permanent doctor team.

There was not a robust recruitment policy and procedure in place. The provider could not demonstrate effective recruitment procedures to ensure patients were cared for, or supported by, suitably qualified, skilled and experienced staff.

We were shown templates of interview questions for GP staff and of an interview and selection form, a checklist for the induction of new staff and job descriptions for all roles. We were told checks were undertaken before staff began work, including checks for relevant qualifications and training, professional registration, identity, criminal records, permission to work in the UK, and references. However, we reviewed the recruitment records of the most recently appointed staff. On the two staff records we looked at we saw no evidence of identity checks, only one reference for one member of staff and no references for another. The practice manager told us that they had omitted to seek references for one staff member who had been recruited through an agency.

Criminal records checks had been carried out for clinical staff and we saw evidence of this on the Disclosure and Barring Scheme (DBS) website. For non-clinical staff there was no documented risk assessment of which staff needed to be subject to a DBS check based on their responsibilities and level of contact with patients. However, the practice manager told us they had considered this recently and decided to arrange a check for all non-clinical staff. This process had been initiated with the practice manager's own application which was awaiting internal identity checks before submission to the DBS. No action had yet been taken regarding the rest of the administrative team.

Checks on professional registration of doctors and nurses were completed on recruitment. Once staff were employed, registration with the Nursing and Midwifery Council (NMC) was checked annually for nurses but not routinely with the General Medical Council (GMC) for doctors.

Dealing with Emergencies

The practice had a continuity plan to deal with emergencies that might interrupt the smooth running of the service, including contingencies for what to do in the event of loss of surgery, utilities, telephones, IT systems and medical records. It also contained risk assessments relating to the loss of personnel, the outbreak of infection, epidemics and pandemics and risks to the premises. Some staff we spoke with were not aware of the continuity plan or what action was expected of them within it.

Equipment

There was equipment available for medical emergencies including a defibrillator, oxygen cylinder and medicines to deal with anaphylactic shock. The equipment was in date and operational, although the oxygen cylinder was stored behind boxes which inhibited access to it. All staff were trained in dealing with medical emergencies.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective in promoting best practice and had arrangements in place to monitor, review, and improve outcomes for people. This was done through internal scrutiny and externally through peer review and participation in local initiatives.

There were arrangements in place to support staff. This included: staff appraisal, learning and professional development opportunities.

The provider worked in collaboration with other health and social care professionals to support particular patient groups. This included mothers and children, older patients, patients with learning difficulties, patients with drug and alcohol problems and homeless people.

The provider promoted good health and prevention. Patients received advice and guidance about making healthy life style choices and were referred to health and well-being schemes.

Our findings

Promoting Best Practice

We saw that care and treatment was delivered in line with recognised best practice standards and guidance, for example through articles published in the British Medical Journal, NICE Clinical Knowledge Summaries (CKS) and the 'GP Hot Topics' update website. Staff carried out assessments which covered all health needs. Care and treatment was planned to meet identified needs and was reviewed at each appointment and at specific intervals, for example for patients with complex health needs.

Where patients lacked capacity, the practice took account of the Mental Capacity Act 2005 and involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment. There were arrangements in place to obtain patients' consent including when obtaining consent from children.

There were appropriate and effective end of life care arrangements in place. End of life care was discussed at weekly clinical meetings and the practice operated a triage system under which the patient's record was flagged for a routine visit. Do not attempt resuscitation (DNAR) decisions were communicated to the out of hour's service (OOH) and London Ambulance Service via the 'Co-ordinate My Care' website. Details of patients on palliative care were faxed directly to the duty doctor.

Management, monitoring and improving outcomes for people

The practice was a member of a local commissioning learning set (CLS) established by West London Clinical Commissioning Group (CCG) for the purposes of fostering collaboration and learning amongst members, benchmarking data, improving performance, sharing good practice, and generating ideas for new services or improvements to existing ones. The practice had taken part in regular CLS audits, for example in dermatology, diabetes, musculoskeletal, and non-elective admissions. The practice collated its results and presented them at monthly CLS peer review meetings. GPs reviewed the outcomes at practice meetings. For example, we saw from an audit of emergency admissions completed in November 2013, the practice had decided on a number of actions including identifying patients most at risk of an emergency admission and adjusting care plans to manage their support and treatment to prevent them.

Are services effective?

(for example, treatment is effective)

There were monthly meetings with a 'buddy' GP practice to review performance data, for example relating to referral practices in light of a target to use community dermatology services rather than send patients to hospital.

Staffing

The practice had an induction process for new staff including an induction checklist. The checklist was not retained on staff records as evidence that the process had been completed satisfactorily. However, one of the most recently recruited staff members confirmed the checklist had been completed when they joined the practice and they had found their induction a thorough and helpful introduction to their role.

There were arrangements in place to support learning and professional development and there was a budget and time off for study provided to enable this. The practice used the NHS e-learning skills academy for health web-site for mandatory training, including equality and diversity, conflict resolution, infection control, child protection, safeguarding of vulnerable adults and fire safety. We were shown the 'training matrix' for all staff which identified when staff were trained, training that was booked and when refresher training would be due. Most mandatory refresher training was up to date but was outstanding in all aspects for one member of staff. The majority of staff were due for refresher training in child protection and all doctors in conflict resolution; infection control, fire safety and safeguarding vulnerable adults.

There were appropriate arrangements for staff appraisal and the revalidation of doctors. Staff confirmed there were annual appraisal meetings which included a review of performance and forward planning, including the identification of learning and development needs. We saw evidence of recently completed appraisal forms, although about half of them had not been signed by the appraiser and appraisee. On going supervision was carried out informally but staff said they felt supported and had ready access to their manager to discuss work issues.

There were policies and procedures in place to manage poor or variable performance of staff and we saw evidence where these had been applied.

Working with other services

There were arrangements in place for engagement with other health and social care providers. The practice participated in the local area 'Paediatric Hub' to provide services and share expertise on the treatment of children. Children served by the practice were discussed with GPs at other practices and other relevant professionals including a paediatric consultant and representative from the West London Clinical Commissioning Group (CCG).

We also saw evidence of external peer review meetings and data referring to inappropriate outpatient referrals, avoidable A&E attendance, and emergency admissions, which identified action the practice was taking in the light of evidence reviewed.

The practice participated in Directed Enhanced Service (DES) schemes to provide annual health checks for patients with learning disabilities, working with the local community learning disabilities team, and an anti-coagulant monitoring service for other practices. The practice also participated in Local Enhanced Services (LES) schemes for shared care prescribing, mental health prescriptions and blood monitoring. Enhanced services are described as essential or additional primary medical services to a higher standard or wider services provided through primary medical service contracts.

A primary care navigator from Age UK had recently started working with the practice to help older patients find their way through the NHS system and provide support with wider issues such as social care, housing, and co-ordinating appointments. The Navigator enabled patients aged 55 and over and their carers to access a wide range of health, social care and voluntary sector services in the community and helped to ensure that there was a co-ordinated approach to that support. A patient we spoke with was complimentary about the support they had received from this service.

The practice had links with the Kensington & Chelsea Community Assessment and Primary Service**,** a self-referral community drug and alcohol treatment and recovery service. There were also links to other local providers of drug and alcohol rehabilitation and recovery services, including those for homeless people and rough sleepers.

Health Promotion & Prevention

There was a large range of health promotion information available at the practice. We were shown the new patient registration form which included information about personal health history, and a summary explanation of use of patients' data and access to their records and data

Are services effective?

(for example, treatment is effective)

protection. Carers UK hold a weekly session at the practice to support carers and carry out carers assessments for the practice population. We saw the related carers form and poster in the reception area. The practice provided vaccinations and immunisations and a cervical screening service. Patients received advice and guidance about making healthy life style choices. The nursing team referred patients to health and wellbeing schemes.

Are services caring?

Summary of findings

Feedback from patients during the inspection was mostly positive about the services they received. They indicated that staff were caring and treated them with dignity and respect. We observed patients being dealt with in a friendly and courteous manner.

The provider delivered a mostly caring service. However there was scope for improvement in ensuring patients' privacy and dignity during telephone calls and their attendance at the practice.

We found patients were involved in decisions about their care. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with legal requirements.

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with seven patients during the inspection and received comments card from six others. The majority of these patients made positive comments about the practice and the service provided. For example, patients told us they had a good impression of the receptionists and were happy with doctors. However, one patient was unhappy with the way they had been dealt with by reception and intended to make a complaint.

During our inspection we overheard and observed mostly good interactions between staff and patients. Reception staff spoke politely and helpfully to patients on the telephone. It was difficult to preserve patient confidentiality due to the reception layout. The reception desk had low access for wheelchair users, and a hearing loop. However, there was nothing to ask patients to stand back while receptionists were seeing another patient or speaking to a patient on the phone. Patients waiting at the reception desk could overhear face to face and telephone conversations with other patients. One patient we spoke with raised their concern about this.

Other aspects of the practice layout also impacted on patient confidentiality and dignity. When sitting in a room next to a consultation room where a patient was being seen, we could hear everything being said between the patient and doctor. Lack of signage on consulting room doors to show they were occupied meant that there was a potential for privacy to be compromised.

The practice took a pro-active approach to end of life care. Staff aimed to follow the Gold Standards Framework (GSF) and clinical staff and the practice manager had received related training. Doctors had links with bereavement counsellors and worked closely with the local palliative care team. They also provided direct bereavement support, by calling patients in or by visiting them. They arranged for other support agencies to come to the practice and invited patients to attend. There were leaflets in the reception area to signpost patients receiving end of life care, their families and loved ones or the recently bereaved to sources of support.

Are services caring?

Involvement in decisions and consent

None of the patients we spoke with raised any concerns about their involvement in decisions about their care. They told us they felt involved in decision making by the doctors, could openly share opinions and the doctors took time to listen to their concerns.

We found, before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. There were arrangements in place to secure the consent of patients who lacked capacity, involving family, carers, social services and advocates where appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We found that the practice understood the needs of its patients and was responsive to them. There were arrangements in place so patients whose first language was not English could access the service and communicate their needs.

There was good collaborative working between the provider and other health and social care services which helped to ensure patients' needs were met. The practice took part in local schemes and projects to provide enhanced services.

The provider engaged with patients to gather feedback on the quality of the service provided and acted on this in order to improve the service.

Some patients were dissatisfied with telephone access to the practice and the availability of routine appointments. The practice had taken steps to improve accessibility but this was under further review.

Our findings

Responding to and meeting people's needs

The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups. For example under the LES for chronic obstructive pulmonary disease (COPD) the practice carried out routine smoking and spirometry screening. If COPD was diagnosed the patient was referred to a GP for further management of the condition. Under the LES 'Putting Patients First' initiative for patients with complex long-term conditions, the practice identified high risk patients and carried out a review of their care planning and needs, including mobility, medication and the need for specialist input and routine hospital attendance.

The Practice was also part of Dementia Direct Enhanced Services (DES) scheme to identify patients who might benefit from screening. Of those identified for screening, we were told a prompt had been placed on their record to invite them for an assessment to detect for possible signs of dementia, including a discussion about their memory. The practice was also taking part in an Imperial College dementia research project, for which patients at the practice had volunteered.

To support patients in residential care GPs at the practice carried out monthly 'ward rounds' at a local care home and a sheltered housing project.

The practice was providing a NHS health check for patients between 40 and 74 years old who did not have a currently diagnosed long-term condition such as heart disease or diabetes.

Two patients mentioned difficulties getting up the stairs to the first floor surgery. One said that they struggled with the stairs but usually the doctor came downstairs to see them. Another told us they found it difficult taking their baby up the stairs to the baby clinic and was worried about having to leave their pram downstairs unlocked. The Practice Manager recognised there were issues about the stairs, in a building which was not purpose built. However, they were usually able to see patients in a consultation downstairs if there was a problem.

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us they had access to an interpretation service for patients for whom English was not a first language and we saw signs offering this service in the reception area. There was an e-mail service, and hearing loop for deaf patients.

There were appropriate arrangements in place for obtaining, communicating and following up the results of diagnostic tests. When patients were referred for hospital appointments, the 'choose and book' service was used – allowing patients to choose their hospital or clinic and book their first appointment.

Patients received support from the practice following discharge from hospital. We heard examples from patients of checks carried out by doctors when they next came to the surgery. We saw from the practice manager's weekly meetings log that referrals and hospital discharge summaries for each week were reviewed by the clinical team, although it was not clear from the log how the reviews were followed up.

Access to the service

Some patients we spoke with were dissatisfied with the appointments system. Patients were generally happy they could get an urgent appointment but felt the wait for non-urgent appointments was too long. Some patients told us they usually had a wait of about two weeks. Other patients mentioned the difficulty in getting through to the surgery by telephone. A number of patients had also posted negative comments about this on the NHS Choices website. In the national patient survey 2012/13 79.8% of patients rated their experience of making an appointment as good or very good, and 76.7% rated their ability to get through on the phone as very easy or easy. Both of these ratings were in the middle range.

We spoke with the practice manager and other staff about the appointments system. Patients could call at 8am for morning appointments and at 1.30pm for the afternoon surgery. 15 emergency slots were available daily. We were told that patients who asked for an urgent appointment were given one and the practice never turned anybody away. There was a walk-in clinic provided for two hours on Mondays and Fridays of each week. The practice also provided telephone consultations. There was an online booking system for appointments. However, a patient survey in 2013/14 showed that not all patients were aware that this was available. The action plan to follow this up had not yet been implemented. We asked if the practice monitored its appointment waiting times and whether it assessed these against national average data. However, the practice did not routinely carry out such monitoring.

Home visits were carried out by the duty GP for patients who were not well enough to attend the surgery. The practice manager received a notification of requests via the reception and referred these to the duty GP to prioritise. Urgent cases were seen on the day and non-urgent within 48 hours. The practice ran a weekly baby clinic on a drop-in basis.

The practice aimed to provide continuity of care to enable patients to see the same doctor at each appointment. Patients we spoke with told us that sometimes they were able to see the same doctor but accepted that this was not always possible, especially for urgent appointments. We also heard they sometimes had to see a locum doctor. Most patients we spoke with said they did not mind whether they saw a male or female doctor, although it was mentioned that there was only one male doctor so the practice may not always be able to meet patients' requests if they did wish to see a male doctor.

The majority of patients we spoke with raised no specific concerns about waiting times when they attended for appointment. However, this was raised as an issue at the most recent patient participation group (PPG) meeting in November 2013. The practice manager undertook to discuss the matter with the reception team with a view to improving communication to patients about delays.

Repeat prescriptions were available within 48 hours. If these were not ready on arrival the GPs were asked to sign the prescription and the practice offered to fax a copy to the patient's pharmacy to speed up collection. For the past two months the practice manager had been allocating all GPs the same volume of repeat prescriptions to ensure equal workloads and reduce the likelihood of delays for patients.

The practice was closed on Wednesday afternoon to enable staff to catch up with administrative tasks and hold practice meetings. The practice leaflet gave details of out of hours services during this and other times when the surgery was closed.

Concerns & Complaints

The practice had a complaints procedure and a complaints leaflet and form were available in the reception area. The

Are services responsive to people's needs?

(for example, to feedback?)

leaflet provided patients with information about the complaints process and who to contact if they were dissatisfied about the outcome. There was also a suggestion box but we were told by staff this was rarely used. The majority of patients we spoke with told us they had no reason to complain. One patient, however, told us during the inspection of their intention to complain about issues they had with reception.

The practice considered and responded to issues raised in writing. The responses did not, however, as a matter of course provide specific information about the independent second stage of the complaints procedure. The practice reviewed complaints at weekly meetings and we saw evidence of this in the practice manager's weekly meetings log. We were shown the practice's 2013-14 log of complaints and compliments which summarised any investigation and the outcome. This included issues raised on the NHS Choices website where patients could record and rate their experience of the service. The practice produced an annual complaints review report which analysed themes and trends and identified action in relation to complaints. The latest report identified the need for a review of the appointment system in 2014-15, and of improvements in the practice's telephone system which the practice manager told us were now under consideration.

The practice had received a '2 star' rating on the NHS Choices website. We noted the practice took these comments seriously and in several cases had posted a response offering to meet the complainant to discuss their concerns further. The practice had also taken action in response to comments posted and where appropriate this was recorded on the website.

Are services well-led?

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

Summary of findings

The leadership, management and governance arrangements did not ensure the service was sufficiently well led.

The practice had stated aims and a mission statement. The governance arrangements included systems to monitor the quality of service, manage risks and learn from incidents. The practice also sought to involve patients and staff to improve service delivery.

However, communication in the practice on management and operational issues was not as effective as it could be. It was not clear that the practice's vision and values had been communicated to staff. The record of practice meetings was not shared with staff and was not up to date. Practice policies and procedures were not systematically reviewed and changes communicated to staff. Staff did not always know who the named leads were for specific areas. It was not clear how lessons learned from incidents were communicated to staff or how identified areas for improvement had been followed up to ensure lessons learned were implemented. It was not clear how recommended controls identified from the practice's health and safety risk assessment were communicated within the practice and followed up and implemented. In addition, the systems in place to identify, assess and manage other risks to the health, safety and welfare of people who use the service and others were not effective.

Our findings

Leadership & Culture

The patient leaflet set out the practice's aim to make a difference to the lives and healthcare of its patients. Its stated mission was to put the patient first, delivering help to those who need it most. We were told it was the practice culture to place more emphasis on good clinical care, rather than written policies and protocols However, it was not clear how the practice vision was articulated. One GP we spoke to was not aware of any stated vision or values. There were individual job descriptions for each post and named leads for specific areas, including clinical governance, safeguarding, prescribing and infection control. Staff we spoke with did not always know who the leads were and there was no formally recorded management structure identifying the lines of responsibility and accountability.

Governance Arrangements

The clinical team and practice manager met weekly to consider practice issues under four main areas covering 'putting patients first', audits, significant events and complaints. Individual patient care planning and treatment was also discussed, including end of life care, and all patient referrals and hospital discharges were reviewed. Safeguarding cases were reported and next steps identified. There were monthly multidisciplinary meetings involving external health and social care professionals, including the district nursing team and social workers. Practice performance data including achievement of Quality and Outcomes Framework (QOF) targets and progress on vaccination programmes were subject to regular review.

Systems to monitor and improve quality & improvement

Audits and checks were carried out by the practice. These included medication management reviews, clinical learning set (CLS) audits, for example on diabetes, gastroenterology and urology. Reviews of performance under the 'Putting Patients First' Local Enhanced Services (LES) scheme were regularly reported and action planned at practice and multidisciplinary team meetings. We saw, for example, discussion recorded for the referral of patients to the local 'Paediatric hub' and the review of end of life

Are services well-led?

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

care management plans. We were shown an audit of the cervical screening service to identify inadequate smears but it contained no information on how the audit results were followed up.

It was not clear how lessons learned from incidents were communicated to staff as the log of weekly meetings where incidents were reviewed was not shared with staff and only brief details were recorded. In addition, it was not always evident from the log how identified areas for improvement had been followed up to ensure lessons learned were implemented.

Patient Experience & Involvement

The practice had a patient participation group (PPG) where members met twice a year with the practice manager to discuss issues relating to improving patients' experiences. At the most recent meeting in November 2013 the PPG agreed patients needed to be educated about practice appointments, opening times and the kind of emergency conditions for which patients should use the nearest urgent care centre rather than attend the practice. The group also agreed on the need to make the practice leaflet more informative in these respects.

We saw also the latest participation report for 2013/14 which included an analysis of a patient survey conducted with input from the PPG. We noted that of the 120 patients who responded, 84% would recommend the surgery to anyone else. The participation report included an action plan for 2013/14. Action included increasing the level of communication with patients, especially around access to services and A&E attendance. There was also an action plan from the November 2013 PPG meeting which included the creation of an email group to facilitate more spontaneous feedback; a review of booked appointments compared to a walk-in system; and the update of the practice leaflet to include better information about the use of services. We were told by the practice manager both action plans had yet to be fully implemented but were planned for completion in 2014/15.

We spoke with two members of the PPG who told us of the useful opportunities to hear though the group about important developments at the practice, such as the introduction of on-line appointment booking, and to put forward ideas and suggestions. Other patients we spoke with showed no awareness of the PPG.

Staff engagement & Involvement

Administrative staff we spoke with felt supported by the practice manager and said the practice team were "like a family". The practice manager felt supported by the GP and nursing team and administrative staff.

Operational issues considered at practice weekly clinical meetings were discussed with administrative staff at their separate weekly meetings the following day, for example on progress of the migration to a new computer system. Working practice issues and complaints and concerns were also discussed at these meetings.

Notwithstanding the arrangements in place to cascade information to staff, we found that communication within the practice was not as effective as it could be. There were no minutes of practice meetings and the practice manager's meetings log recorded only brief, and sometimes for administrative staff meetings, no details of issues discussed. The meetings log was not made available to clinical or administrative staff and was not up to date at the time of our inspection. The last weekly meeting recorded was on 25 March 2014. In addition it was not clear from the log how issues discussed had been followed up and action implemented.

There was no systematic review of practice policies and procedures and we noted that several had not been updated for some time to ensure they were still fit for purpose. Reviews and updates were made on an ad hoc basis and we noted recent updates in 2014, for example to the policies on whistleblowing, dignity at work, grievance, maternity leave and staff confidentiality at work. However, there was no formal process for communicating changes to staff and ensuring they had read and understood the new policy or procedure. For example, none of the administrative staff were aware of the practice's recently updated whistleblowing policy, although they were able to say who they would speak to if they had any concerns. The practice's health and safety risk assessment had also not been communicated to staff.

Learning & Improvement

Staff received annual appraisals. They undertook a range of mandatory training which was supplemented by other training to support staff in their development and help them in carrying out their roles. Clinical staff were supported in completing continual professional development required to maintain their professional registration.

Are services well-led?

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

Identification & Management of Risk

The practice's business continuity plan included a risk assessment to take account of and manage a range of risks which could interrupt service delivery. The practice had completed a health and safety risk assessment in April 2014, although staff were not aware of this. Recommended controls were identified but we found these were not all followed up and implemented. For example, regular washing of children's toys with disinfectant was recommended but this was not included on the cleaning schedule and there was no record that the cleaning was carried out. A further potential hazard identified in the risk assessment was confusion if there was a fire. However, there had been no fire drills in the practice for some time and there was no regular testing of the alarm system between the annual checks. In addition, there was no up to date record of portable appliance testing (PAT) and no evidence of gas boiler servicing. These gaps in records had not been identified and assessed as potential risks to the health, welfare and safety of people using the service, staff and other visitors to the practice.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to older people was generally effective, caring and responsive. There were effective arrangements in place to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned to meet identified needs of patients over age 75 and was reviewed. There was evidence of arrangements in place and engagement with other health and social care providers. For example, a primary care navigator from Age UK had recently started working with the practice as part of a project to support older people in gaining access to NHS services. Patients were referred to health and wellbeing schemes.

There were appropriate and effective end of life care arrangements in place. The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups which also covered older people. The Practice was also part of a Dementia Direct Enhanced Services (DES) scheme to identify who would benefit from screening. Home visits were carried out by the duty GP for those who were not well enough to attend the surgery

Our findings

Safe

There were arrangements in place to ensure patients within the over 75 population group were kept safe. However, shortcomings in relation to the safety and security of the practice premises, infection control, staff recruitment practices and security of records did not protect patients in this and other population groups sufficiently against the risks associated with these areas.

There were effective arrangements in place to identify vulnerable and frail older people at risk of abuse. There was access to the practice for patients with mobility difficulties. The stairs to the second floor treatment rooms were a potential barrier to older people but arrangements were made for doctors and nurses to see them on the ground floor.

Effective

Care and treatment was planned to meet identified needs of patients over age 75 and was reviewed. Where patients lacked capacity the practice took account of the Mental Capacity Act 2005 and there were arrangements in place to obtain patients' consent, for example because their cognitive abilities had been impaired due to the symptoms of dementia. There were appropriate and effective end of life care arrangements in place.

There was evidence of arrangements in place and engagement with other health and social care providers.

A primary care navigator from Age UK had recently started working with the practice as part of a project to support older people in gaining access to NHS services.

There was a large range of health promotion information available at the practice including information about services available to older people. There was a system for assessing the support needs of carers and we saw the relevant carers form and poster in the reception area. The

Older people

practice provided annual flu vaccinations. Patients received advice and guidance about making healthy life style choices. The nursing team referred patients to health and well-being schemes.

Caring

There were arrangements in place to ensure the practice provided a caring service for older people who were aged 75 years or older.

The reception desk had low access for wheelchair users, and a hearing loop.

The practice took a pro-active approach to end of life care. Doctors had links with bereavement counsellors and worked closely with the local palliative care team. They also provided direct bereavement support and arranged for other support agencies to come to the practice and invited patients to attend for support. There were leaflets in the reception area to signpost patients receiving end of life care, their families and loved ones or the recently bereaved to sources of support.

Patients in this population group were involved in decisions about their care. We heard from them that they understood what the doctors and nurses told them.

Responsive

There were arrangements in place to ensure the service was responsive to the needs of older people who were aged 75 years or older.

The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups which also covered older people, for example schemes for chronic obstructive pulmonary disease (COPD) and patients with complex long-term conditions.

The Practice was also part of Dementia Direct Enhanced Services (DES) scheme to identify who would benefit from screening. They also took part in an Imperial College London dementia research project, for which patients at the practice had volunteered.

Patients were mostly happy they could get an urgent appointment but some felt the wait for non-urgent appointments was too long. Older patients we spoke with or who completed comment cards told us they usually had to wait about two weeks.

Home visits were carried out by the duty GP for those who were not well enough to attend the surgery.

Older patients we spoke with told us they could usually see their preferred GP. For non-urgent appointments though, sometimes this meant waiting a long time to get an appointment and a long wait to see the GP when they came for the appointment.

Well led

There were arrangements in place to ensure the practice was well led for the general population which also applied for older people. The practice sought to involve patients and staff in the improvement of service delivery. However, the leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to people with long term conditions was generally effective, caring and responsive. There were safe arrangements in place to manage repeat prescriptions for people with long term conditions. The provider had effective arrangements in place to help patients manage their long term conditions. The practice took part in regular clinical learning set (CLS) audits relating to long term conditions, for example diabetes and musculoskeletal conditions.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups with long term conditions.

Our findings

Safe

There were arrangements in place to ensure people with long term conditions were kept safe. However, shortcomings in relation to the safety and security of the practice premises, infection control, staff recruitment practices and security of records did not protect patients in this and other population groups sufficiently against the risks associated with these areas.

There were safe arrangements in place to manage repeat prescriptions for people with long term conditions. This included medication dosage which needed to be checked against blood test results, for example for methotrexate, immunosuppressive agents and warfarin.

Effective

We found the provider had effective arrangements in place to help patients manage their long term conditions.

There were effective arrangement in place to monitor the effectiveness of referrals to secondary health care, such as medical specialists and consultants.

The practice took part in regular clinical learning set (CLS) audits relating to long term conditions for example diabetes, and musculoskeletal conditions. The practice collated its results and presented them at monthly CLS peer review meetings. GPs reviewed the outcomes at practice meetings.

There were arrangements in place to ensure the flow of information between the practice and other healthcare professionals, such as district nurses. This ensured continuity of care for patients with long term conditions.

Caring

There were arrangements in place to ensure the practice provided a caring service for people with long term conditions. Patients were mostly positive about the compassion, dignity and respect they were shown.

People with long term conditions

Patients were involved in decisions about their care. We found, before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes

Responsive

There were arrangements in place to ensure the service was responsive to the needs of people with long term conditions.

We saw there were arrangements in place to meet the specific needs for those patients who needed additional support, for example, with communication or mobility needs.

The practice participated in a number of Local Enhanced Services (LES) schemes to improve the management and delivery of care to specific patient groups with long term conditions, for example schemes for chronic obstructive pulmonary disease (COPD) and patients with complex long-term conditions.

Patients received support from the practice following discharge from hospital.

Patients were mostly happy they could get an urgent appointment but felt the wait for non-urgent appointments was too long. Home visits were carried out by the duty GP for those who were not well enough to attend the surgery.

Well led

There were arrangements in place to ensure the practice was well led for the general population which also applied for people with long terms conditions. The practice sought to involve patients and staff in the improvement of service delivery. However, the leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to mothers, babies, children and young people was generally effective, caring and responsive. There were effective arrangements in place to safeguard children and young people. There were arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people.

Our findings

Safe

There were arrangements in place to ensure mothers, babies, children and young people were kept safe. However, shortcomings in relation to the layout and maintenance of the practice premises, infection control, staff recruitment practices and security of records did not protect patients in this and other population groups sufficiently against the risks associated with these areas.

There were effective arrangements in place to safeguard children and young people. There were procedures in place to identify abuse and reduce the risk of abuse happening. All staff had been trained in spotting and dealing with child protection issues. The doctors we spoke said they were not aware of any incidences of female genital mutilation (FGM) within the practice or local area.

There were arrangements in place to ensure good communication with other professionals involved in the health and social care of children and young people. The practice participated in the local area 'Paediatric Hub' to provide services and share expertise on the treatment of children.

The practice provided a weekly baby clinic on a drop-in basis run by a health visitor on Thursday afternoons. Clinics were also run for child health care surveillance, contraceptive services, maternity medical services, immunisations and vaccinations. Expectant mothers and babies had medical support from nurses and health visitors, delivered in conjunction with the practice.

Effective

There were arrangements in place to ensure treatment was effective for mothers, babies, children and young people.

We saw the practice had carried out a paediatric A&E attendance audit in March 2014. Action from the audit included communication with patients who attended A&E frequently, inviting them to attend the local 'Paediatric hub.

Mothers, babies, children and young people

There were follow up arrangements in place following the birth of a child, to check on progress and offer support to mother and child. These included post-natal checks to ensure the health needs of both child and mother were considered at an early stage and the offer of immunisations.

Information leaflets were available in the reception area relevant to mothers, babies, children and young people.

Caring

There were arrangements in place to ensure the practice provided a caring service for mothers, babies, children and young people.

One patient from this population group we spoke with told us they found it difficult taking their baby up the stairs to the baby clinic and was worried about having to leave their pram downstairs unlocked. They also expressed dissatisfaction with the way they had been dealt with by staff and the lack of privacy and confidentiality of the reception area.

Responsive

There were arrangements in place to ensure the practice provided a responsive service for mothers, babies, children and young people.

Expectant mothers and babies had medical support from nurses and health visitors, delivered in conjunction with the practice.

Well led

There were arrangements in place to ensure the practice was well led for the general population which also applied for mothers, babies, children and young people. The practice sought to involve patients and staff in the improvement of service delivery. However, the leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The service to working age people (and those recently retired) was generally effective, caring and responsive. Patients were asked for their consent to treatment and felt involved is decisions about their care. Patients received advice and guidance about making healthy life style choices. The provider had effective processes in place for the referral of patients to secondary care. Evening clinics were available for those patients who could not get to the surgery during regular working hours.

Our findings

Safe

There were arrangements in place to ensure working age people (and those recently retired) were kept safe. However, shortcomings in relation to the safety and security of the practice premises, infection control, staff recruitment practices and security of records did not protect patients in this and other population groups sufficiently against the risks associated with these areas.

The patients we spoke with in this population group raised no concerns about their safety in using the service.

Effective

There were arrangements in place to ensure treatment was effective for people of working age and those recently retired.

The new patient application process considered social factors, such as smoking and drinking alcohol. Advice was given as part of this process about reducing the risks associated with social lifestyle choices. There were leaflets displayed in the waiting room for patients to access. These included information about common conditions and their symptoms, promotion of healthy lifestyles, and prevention of ill health. Patients received advice and guidance about making healthy life style choices. The service also offered smear tests to patients when needed.

The practice was providing a NHS health check for patients between 40 and 74 years old who do not have a currently diagnosed long-term condition such as heart disease or diabetes.

The provider had effective processes in place for the referral of patients to secondary care. Regular audits were carried out to check the appropriateness of referrals and whether they might have been managed in primary care.

Caring

There were arrangements in place to ensure the practice provided a caring service for people of working age and those recently retired.

Working age people (and those recently retired)

Feedback from patients in this population group was mostly positive about the way staff treated them. We observed staff being courteous and respectful towards patients both face to face and over the telephone.

We found, before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Patients told us they felt involved in decisions about their care and treatment.

Responsive

There were arrangements in place to ensure the practice provided a responsive service for people of working age and those recently retired.

Evening clinics were available for those patients who could not get to the surgery during regular working hours.

Patients we spoke with from this population group were mostly happy they could get an urgent appointment but some felt the wait for non-urgent appointments was too long.

Patients we spoke with told us they had not had any reason to make a formal complaint about the service.

Well led

There were arrangements in place to ensure the practice was well led for the general population which also applied for working age people (and those recently retired). The practice sought to involve patients and staff in the improvement of service delivery. However, the leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The arrangements in place for the general population also sought to ensure treatment was effective, caring and responsive for people in vulnerable circumstances who may have poor access to primary care. There were effective arrangements in place to identify vulnerable people at risk of abuse. Patients who spoke a different language had access to an interpretation service. There was a system for assessing the support needs of carers. The practice was signed up to a Directed Enhanced Service (DES) scheme to provide annual health checks for patients with learning disabilities.

Our findings

Safe

There were arrangements in place to ensure people in vulnerable circumstances who may have poor access to primary care were kept safe. However, shortcomings in relation to the safety and security of the practice premises, infection control, staff recruitment practices and security of records did not protect patients in this and other population groups sufficiently against the risks associated with these areas.

There were effective arrangements in place to identify vulnerable patients at risk of abuse. However, with the exception of patients with learning difficulties, the practice's safeguarding policies and procedures made no specific references to patients in this population group.

Effective

The arrangements in place to ensure treatment was effective for the general population also sought to ensure it was effective for people in vulnerable circumstances who may have poor access to primary care. However, during the inspection we did not review specific evidence of policies or practices related to the majority of patients within this population group.

The practice was signed up to a Directed Enhanced Service (DES) scheme to provide annual health checks for patients with learning disabilities working with the local community learning disabilities team.

Caring

There were arrangements in place to ensure the practice provided a caring service for patients in general but we did not identify specific evidence of policies or practices directed towards patients within this population group, with the exception of patients with learning difficulties.

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

Patients who spoke a different language had access to an interpretation service. Patients whose first language was not English were therefore supported to access the service and communicate their needs.

There was a system for assessing the support needs of carers and we saw the relevant carer's form and poster in the reception area.

Responsive

The arrangements in place to ensure treatment was responsive toward patients in in the general population also sought to ensure it was responsive for people in vulnerable circumstances who may have poor access to primary care. During the inspection we did not review specific evidence of policies or practices related to the majority of patients within this population group.

However, the practice leaflet stated a commitment to equality in the provision of services to all who came into contact with the practice.

Well led

There were arrangements in place to ensure the practice was well led for the general population which also applied for people in vulnerable circumstances who may have poor access to primary care. The practice sought to involve patients and staff in the improvement of service delivery. However, the leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

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 arrangements in place to ensure the service was safe were not adequate. Patients in this and other population groups were not protected sufficiently against the risks of infection, unsafe and unsuitable premises, those associated with the recruitment of staff and the security of records.

The leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

The arrangements in place for the general population also sought to ensure treatment was effective, caring and responsive for people experiencing poor mental health. However, during the inspection we did not review specific evidence in these areas relating to patients within this population group.

Our findings

Safe

There were arrangements in place to ensure people experiencing poor mental health were kept safe. However, shortcomings in relation to the safety and security of the practice premises, infection control, staff recruitment practices and security of records did not protect patients in this and other population groups sufficiently against the risks associated with these areas.

There were effective arrangements in place to identify vulnerable patients at risk of abuse.

Effective

The arrangements in place to ensure treatment was effective for the general population also sought to ensure it was effective for people experiencing poor mental health.

The practice had access to the services of a mental health worker and there were regular meetings with multidisciplinary teams to consider the needs of patients in this population group.

Where patients lacked capacity, the practice took account of the Mental Capacity Act 2005 and involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment. There were arrangements in place to obtain patients' consent.

Caring

There were arrangements in place to ensure the practice provided a caring service for patients in general but we did not identify specific evidence relating to patients within this population group.

There was a system for assessing the support needs of carers and we saw the relevant carer's form and poster in the reception area.

Responsive

The arrangements in place to ensure treatment was responsive toward patients in the general population also sought to ensure it was responsive for people experiencing

People experiencing poor mental health

poor mental health. We did not identify specific evidence related to this this population group. However, the practice participated in Local Enhanced Services (LES) schemes regarding mental health prescriptions and related blood monitoring.

Well led

There were arrangements in place to ensure the practice was well led for the general population which also applied for people experiencing poor mental health. The practice sought to involve patients and staff in the improvement of service delivery. However, the leadership, management and governance arrangements did not ensure the service was sufficiently well led for patients in this and other population groups.

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 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Patients were not sufficiently protected from the risk of infection by the effective operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections, and by maintaining appropriate standards of cleanliness and hygiene in relation to premises and equipment. (Regulation 12 (1) and (2)(c)(i) and (ii))

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Patients were not sufficiently protected from the risk of infection by the effective operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections, and by maintaining appropriate standards of cleanliness and hygiene in relation to premises and equipment. (Regulation 12 (1) and (2)(c)(i) and (ii))

Regulated activity	Regulation
Surgical procedures	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Patients were not sufficiently protected from the risk of infection by the effective operation of systems designed to assess risk, prevent, detect and control the spread of

This section is primarily information for the provider

Compliance actions

	health care associated infections, and by maintaining appropriate standards of cleanliness and hygiene in relation to premises and equipment. (Regulation 12 (1) and (2)(c)(i) and (ii))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Patients were not sufficiently protected from the risk of infection by the effective operation of systems designed to assess risk, prevent, detect and control the spread of health care associated infections, and by maintaining appropriate standards of cleanliness and hygiene in relation to premises and equipment. (Regulation 12 (1) and (2)(c)(i) and (ii))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. (Regulation 15(1)(a),(b) and (c)(i))

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. (Regulation 15(1)(a),(b) and (c)(i))

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Surgical procedures	Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. (Regulation 15(1)(a),(b) and (c)(i))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Patients were not sufficiently protected from the risks associated with unsafe or unsuitable premises. (Regulation 15(1)(a),(b) and (c)(i))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. Patients were not fully protected against all the risks associated with the recruitment of staff. This was because the recording of recruitment information was limited and not all appropriate pre-employment checks had been carried out or recorded prior to a staff member taking up post. (Regulation 21 (a) and (b))

Regulated activity	Regulation
Maternity and midwifery services	Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. Patients were not fully protected against all the risks associated with the recruitment of staff. This was

This section is primarily information for the provider

Compliance actions

because the recording of recruitment information was limited and not all appropriate pre-employment checks had been carried out or recorded prior to a staff member taking up post. (Regulation 21 (a) and (b))

Regulated activity	Regulation
Surgical procedures	Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. Patients were not fully protected against all the risks associated with the recruitment of staff. This was because the recording of recruitment information was limited and not all appropriate pre-employment checks had been carried out or recorded prior to a staff member taking up post. (Regulation 21 (a) and (b))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. Patients were not fully protected against all the risks associated with the recruitment of staff. This was because the recording of recruitment information was limited and not all appropriate pre-employment checks had been carried out or recorded prior to a staff member taking up post. (Regulation 21 (a) and (b))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because records about them were not always kept securely. (Regulation 20(2)(a))

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Maternity and midwifery services	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because records about them were not always kept securely. (Regulation 20(2)(a))

Regulated activity	Regulation
Surgical procedures	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because records about them were not always kept securely. (Regulation 20(2)(a))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because records about them were not always kept securely. (Regulation 20(2)(a))

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Compliance actions

The provider did not have an effective system in place to assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. (Regulation 10 (1)(a) and (b))

Regulated activity	Regulation
Maternity and midwifery services	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. (Regulation 10 (1)(a) and (b))

Regulated activity	Regulation
Surgical procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. (Regulation 10 (1)(a) and (b))

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have an effective system in place to assess and monitor the quality of services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. (Regulation 10 (1)(a) and (b))