

The Wellington Health Centre

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Wellington Health Centre on 2 December 2014. Overall the practice is rated as Good.

Specifically, we found the practice to be good for providing, effective, caring, responsive and well-led services. It was also good for providing services to the six population groups we looked at: older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances may make them vulnerable; and people experiencing poor mental health (including people with dementia).

We found the practice requires improvement for providing safe services.

Our key findings were as follows:

- The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice understood the needs of its patients and was responsive to these. It recognised the needs of different groups in the planning of its services.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.

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

Summary of findings

Importantly, the provider must:

- Ensure training records are fully completed to ensure patients are fully protected from the risks of unsafe or inappropriate care and treatment by the accurate maintenance of records about staff employed to carry out the regulated activities.
- Put in place arrangements to ensure medicine stocks are managed safely.

In addition the provider should:

- Arrange for all staff to receive formal training in safeguarding of vulnerable adults.
- Ensure the assurances provided to the local PHE/NHS England immunisations coordinator are adhered to and the policy for ensuring medicines are kept at the required temperatures is followed at all times.

- Take steps to raise staff awareness of the Mental Capacity Act 2005 especially in relation to understanding of deprivation of liberty safeguards (DOLs).
- Communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure non-clinical staff who occasionally act as chaperones undergo a criminal records check.
- Complete a documented risk assessment stating the rationale for not carrying out a criminal records check for some non-clinical staff.
- Formally record the checks of medicine expiry dates and medical emergencies equipment. In addition, all staff trained to deal with medical emergencies should receive annual update training to fully meet UK Resuscitation Council guidelines.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services. Risks to patients were assessed and systems and processes to address these risks were in place but they were not always implemented well enough to ensure patient safety.

The practice had an effective system in place for managing significant events, incidents and accidents and for communicating lessons learned to support improvement. There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE).

The practice had appropriate safeguarding policies in place for both children and vulnerable adults. However, details were not available about the child protection training undertaken by for one of the nursing staff and the majority of staff had not completed formal training in safeguarding of vulnerable adults.

There was a chaperone policy, which was visible on the waiting room noticeboard but was not displayed in all consulting rooms we visited. In addition some non-clinical staff who occasionally acted as chaperones had not undergone a criminal records check.

The policy for ensuring medicines were kept at the required temperatures was not always followed and we identified potential breaches. Following the inspection the practice raised this as a clinical incident with the local PHE/NHS England immunisations coordinator. As a result of assurances provided by the practice, the coordinator recommended the incident for closure.

Medicines were available to deal with medical emergencies. However, no records were kept of the checks carried out by staff of expiry dates. In addition there was no system for recording and monitoring the medicine stock levels.

Appropriate equipment was available for medical emergencies and we saw it was operational. Regular checks were carried out on the equipment but the checks were not recorded. In addition, some staff trained to deal with medical emergencies required update training to meet UK Resuscitation Council guidelines.

There were robust infection control policies and procedures in place. However, details were not available about the most recent training undertaken by three GPs and two of the nursing staff.

The practice had appropriate processes for recruiting staff, including the required pre-employment checks. The practice had taken the

Requires improvement



Summary of findings

decision not to carry out criminal records checks for non-clinical staff who had been employed at the practice for a number of years. However, a documented risk assessment identifying and minimising any risks had not been undertaken stating the rationale for this decision.

Are services effective?

The practice is rated as good for providing effective services. The practice scored positively in their QOF performance and used QOF to steer practice activity. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. The practice participated in clinical audit and routinely collected information to review and improve patient care and outcomes. The practice worked in collaboration with other health and social care professionals to provide a multidisciplinary approach to their care and treatment. The practice had a consent protocol which staff were aware of and followed. However, staff knowledge and understanding of mental capacity needed further development. There were appropriate arrangements in place to support staff appraisal, learning and professional development. The practice promoted good health and prevention.

Good



Are services caring?

The practice is rated as good for providing caring services. Data from the national GP patient survey showed the practice was rated above the CCG average for care and concern and on consultations with doctors and nurses. Scores from the practice's own patient survey showed overall there was a good degree of satisfaction with the medical staff, medical services and administrative staff. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect and involved them in decisions about their care and treatment. We observed during the inspection that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided appropriate support for end of life care and patients and their carers received good emotional support. a from the national GP patient survey showed the practice was rated above the CCG average for care and concern and on consultations with doctors and nurses. Scores from the practice's own patient survey showed overall there was a good degree of satisfaction with the medical staff, medical services and administrative staff. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect and involved them in decisions about their care and

Good



Summary of findings

treatment. We observed during the inspection that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice understood the needs of its patients and was responsive to these. Data from the national GP patient survey showed the practice was rated above average in the CCG area for convenience, experience of making an appointment and waiting times, and for being able to see or speak to their preferred GP. The views from patients we spoke with were mostly positive about access to the service. The practice had taken a number of steps to improve accessibility in the light of feedback, for example, the provision of walk-in clinics. There was an effective complaints system. Staff we spoke with understood the complaints procedure and there was documentary evidence to confirm that lessons learned had been communicated throughout the practice, for example, at practice meetings. The premises and services had been adapted to meet the needs of people with disabilities.

Good



Are services well-led?

The practice is rated as good for being well-led. The practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service. The practice's aims were set out in its statement of purpose, practice leaflet and website and staff were committed to these aims. There was a clear leadership structure with named members of staff in lead roles. There was an open culture, staff were clear about their own roles and responsibilities and felt supported in their work. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice had a range of policies and procedures to govern activity. There were arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice has an ongoing programme of regular governance meetings. Staff had received induction training and regular performance reviews. The practice proactively sought feedback from staff and patients, including a patient participation group (PPG), which it acted on.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. There were effective risk assessment processes in place. The practice worked closely with a care navigator and regularly reviewed its unplanned hospital admissions register to agree follow up action for potentially vulnerable patients on discharge so that the right services were accessed and available. The practice had close links with the district nurses and in multidisciplinary team meetings reviewed patient care with them for housebound and vulnerable patients. Each patient over 75 had a named GP. They also had care plans which were actively added to and amended as circumstances changed. For older patients and patients with long term conditions home visits were available. Flu vaccinations were provided to older people in at risk groups. The practice offered respite care for carers and the practice's patient participation group had a support group for elderly patients who could provide support at home if needed. There were appropriate and effective end of life care and bereavement support arrangements in place.

Good



People with long term conditions

The practice is rated good for the care of people with long term conditions. The practice provided services for patients with diabetes, hypertension and chronic obstructive pulmonary disease (COPD). Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance. All patients with one or more long term conditions had care plans and were proactively recalled for a review using a computerised recall system and also opportunistically during consultations. Diabetic patients were referred to the local community diabetic clinic. The needs of new diabetic patients were reviewed and referred to appropriate education programme, a dietician and eye screening. Patients with repeat prescriptions were audited annually and asked to see a doctor to review their medication. Flu and pneumococcal vaccinations were offered to patients in at risk groups, including patients with long term conditions. For patients with long term conditions home visits were available and longer appointments were provided when needed.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. The practice provided a family planning service

Good



Summary of findings

during normal surgery times, including a coil fitting service and smear testing. The practice's performance for cervical smear uptake was 75%, which was above the CCG average. The practice offered a full range of immunisations for children. Flu vaccination was offered to pregnant women. There were procedures in place to safeguard children and young people from abuse. Both clinical and non-clinical staff had received child protection training in line with national guidance. There was a system to highlight vulnerable patients and families on the practice's electronic records. There were multidisciplinary team meetings fortnightly to review vulnerable patients and families. The practice was also part of the local multi-agency safeguarding hub (MASH). This provided a secure email address for sending safeguarding information to social services and enabled the practice to highlight any concerns about family members. Paediatric care was co-ordinated with the community paediatric outreach clinic to ensure parents and their children were invited to attend the clinic when necessary. The practice provided ante care during normal surgery times and a baby clinic twice weekly with health visitors. There were baby changing facilities.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice was accessible to working people. For example, appointments were available until 7pm on Monday and Tuesday. Telephone advice was available throughout the day by the doctors and nurses and the practice tried to ensure that this was at times that suited its working population. The practice offered a health check to all new patients registering with the practice. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice offered a full range of health promotion and screening which reflected the needs for this age group. Health and exercise advice was given at routine appointments. Appointments could be booked on line and repeat prescriptions ordered electronically. The practice offered smoking cessation advice and support. Flu vaccinations were offered to patients aged 65 and older and travel vaccinations and advice. The practice website included self-care health advice with links to a range of information and guidance. A wart clinic was held twice monthly. The practice offered well person checks to discuss lifestyle and advise patients on ways to minimise health risk factors. The practice referred patients to the local 'MyAction' cardiovascular prevention programme run by a local NHS trust.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There was an open door policy and vulnerable groups such as the homeless could receive treatment. Street sex workers, patients with alcohol problems and drug users were referred to appropriate services locally. The practice kept a register of all patients with a learning disability and routinely recalled them to review and check their physical health and well-being. They were offered longer appointments to facilitate this and were supported to make decisions through the use of care plans, which they were involved in agreeing. There were multidisciplinary team meetings fortnightly to review vulnerable patients and families. Staff knew how to recognise signs of abuse in vulnerable adults and the process to follow in the event of any safeguarding concerns. However, the majority of staff had not completed formal training in this area. If needed, translation services were available for patients who did not have English as a first language. The premises and services had been adapted to the needs of patients with a disability.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). There was an in-house psychiatric nurse available at the practice on Mondays. Patients with mental health problems could book an appointment with the nurse for non-urgent counselling and advice. Patients on the mental health register were reviewed six-monthly and it was recorded on the register what action to take in the event of a crisis, including open access to a GP and out-of-hours contact with the community psychiatric nurse. The practice monitored repeat prescribing for people receiving medication for mental ill-health and undertook reviews when repeat limits were reached. There were regular reviews and medication management plans and recall protocols in place for patients on high risk medicines, including medicines for patients with mental health conditions. A community dementia nurse had trained doctors to use the General Practitioner assessment of Cognition (GPCOG) screening tool and they were now using this for diagnosing dementia. Clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. However, this was an area that the practice acknowledged needed further development.

Good



Summary of findings

What people who use the service say

On the day of our inspection we also spoke with seven patients, including two representatives of the practice's patient participation group (PPG). The majority of patients were positive about the service experienced. Patients felt the practice was safe, clean and hygienic. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Patients told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. A minority of patients were less positive raising issues mainly about the time taken for the telephone to be answered and delays in booking an appointment with a named doctor.

The mostly positive comments were reflected in the national patient survey 2013/14 where the practice scored above the CCG average for patient satisfaction for being treated with care and concern and for satisfaction with consultations with the doctor and nurses. We also looked at the patient survey of 54 patients conducted through the PPG for 2013/2014. The PPG survey asked different questions but overall satisfaction was good and confirmed by 82% of patients definitely recommending the surgery to others. Respondents felt doctors were caring, patient and professional.

Two patients we spoke with told us the recent sudden departure of a longstanding GP had led to some patients feeling unsettled. This had been compounded by many of

the patients not knowing that the GP was leaving or had left. One patient we spoke with told us the GP leaving had been particularly upsetting and it had been difficult to adjust to a new GP.

The two members of the PPG we spoke with told us the surgery opening hours had been changed in response to patient survey results. The introduction of walk-in clinics had proved particularly popular. Saturday morning opening had also been indicated as potentially useful on the annual patient survey and we were told discussions had taken place with practice manager regarding this. However, it was decided at the time that this was not possible in light of funding and budgetary constraints. We noted from the 2014 PPG report that other issues raised about the appointment system included difficulty in getting to speak to a GP on the telephone and waiting times for consultations to start. These issues were being taken forward in the PPG action, although waiting times were acknowledged ongoing problem both the PPG and practice had been working on together for some time with no obvious solution.

We were told the PPG felt the premises needed some attention as the building environment was beginning to look tired. They were aware there were ongoing issues regarding the tenancy of the building and that the practice agreed with them about the premises. However, at the current time it was difficult to invest in the building until tenancy issues had been resolved. The lead partner GP and practice manager confirmed that the practice was seeking to resolve tenancy issues with the landlord in order to progress improvements to the premises.

Areas for improvement

Action the service **MUST** take to improve

- Ensure training records are fully completed to ensure patients are fully protected from the risks of unsafe or inappropriate care and treatment by the accurate maintenance of records about staff employed to carry out the regulated activities.
- Put in place arrangements to ensure medicine stocks are managed safely.

Action the service **SHOULD** take to improve

- Arrange for all staff to receive formal training in safeguarding of vulnerable adults.
- Ensure the assurances provided to the local PHE/NHS England immunisations coordinator are adhered to and the policy for ensuring medicines are kept at the required temperatures is followed at all times.

Summary of findings

- Take steps to raise staff awareness of the Mental Capacity Act 2005 especially in relation to understanding of deprivation of liberty safeguards (DOLs).
- Communicate the practice's chaperone policy more clearly to patients in clinical areas.
- Ensure non-clinical staff who occasionally act as chaperones undergo a criminal records check.
- Complete a documented risk assessment stating the rationale for not carrying out a criminal records check for some non-clinical staff.
- Formally record the checks of medicine expiry dates and medical emergencies equipment. In addition, all staff trained to deal with medical emergencies should receive annual update training to fully meet UK Resuscitation Council guidelines.

The Wellington Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a practice specialist, and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP, practice specialist and expert by experience were granted the same authority to enter the practice as the CQC inspector.

Background to The Wellington Health Centre

The Wellington Health Centre provides primary medical services through a Personal Medical Services (PMS) contract to around 6,700 patients in the St Johns Wood, Primrose Hill and Maida Vale areas of North West London. The patient population includes a cross-section of socio-economic and ethnic groups, mostly 'White', 'White/British' or 'Asian'. The two most common languages spoken by patients are English and Arabic. There is a spread of age groups served by the practice. There are above average numbers in the 25-44 age groups.

The practice team is made up of a GP partner, four salaried GPs, three locum GPs, the practice manager partner, Assistant practice manager, two nurses and a locum nurse, a practice secretary, an IT Administrator and four reception staff. Six of the GPs are female and two male.

Appointments are available from 08:00 to 11:30 and 14:00 to 19:00 on Monday and Tuesday; 08:00 to 12:30 and 14:00 to 17:00 Wednesday and Thursday and 07:00 to 11:30 and

14:00 to 17:30 on Friday. The practice also ran a walk-in clinic on Monday, Tuesday and Friday mornings from 10.30 to 11.30 for any patient with an urgent need for a same-day appointment.

Out-of-hours (OOH) patients are advised to call the 111 service for healthcare advice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We liaised with Central London (Westminster) Clinical Commissioning Group (CCG), Healthwatch Westminster and NHS England.

We carried out an announced visit on 2 December 2014. During our visit we spoke with a range of staff including 3

GPs, a nurse, the practice manager and assistant practice manager, an IT administrator and four reception staff. We also spoke with seven patients who used the service, including two members of the practice's patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed information that had been provided to us prior to and at the inspection 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?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a locum GP found that patient referrals they had raised had not been arranged because they had not followed the practice's referral protocol. As soon as this came to light, the practice searched on its patient record system to identify patients affected and arranged for delayed referrals to be made. Patients affected were informed and given an explanation and apology. The locum was provided with training in the practice's referrals protocol and lessons learned were discussed within the practice. An action plan was put in place to ensure all referrals were undertaken in same manner and to encourage patients to contact practice if not heard anything about their referral within 2 weeks.

We saw evidence of incident reports documented for the last 12 years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were a standing item on the practice meeting agenda and we saw evidence in meeting minutes where significant events and complaints had been discussed. Any actions highlighted at the practice meetings would be actioned and then reviewed bi-annually. There was evidence that the practice had learned from these incidents and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw records were completed in a comprehensive and timely manner and included suggestions to prevent recurrence and specific action required. The practice kept records of significant events and details of these were made available

to us before the inspection for events that had occurred during the last year. These records provided a summary of the event, a risk assessment of the potential consequences, the action taken and the learning outcomes. The practice informed NHS England of incidents of potential patient harm. We saw evidence of action taken as a result of incidents. For example, a patient starting on new medicine was initially prescribed the wrong dose. This was picked up by the pharmacist and was reviewed at a practice clinical/educational meeting. Lessons learned were communicated to clinical staff and included as a development objective in the appraisal of the clinician concerned.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The practice manager and a nominated GP lead were responsible for reviewing and distributing any alerts and guidelines to staff within the practice. The practice told us of the recent best practice guidelines on Ebola which had been disseminated to staff and posters placed in the reception area.

Reliable safety systems and processes including safeguarding

The practice had a child protection policy in place which included contact details for local safeguarding agencies. The practice did not have its own policy for safeguarding of vulnerable adults. However, the practice referred the Westminster Safeguarding Vulnerable Adults Multi-Agency policy and procedures, which was available to staff on the practice's intranet. The practice had a nominated GP lead for safeguarding and staff we spoke with knew who the lead was, how to recognise signs of abuse and the process to follow. Details of local safeguarding contacts were available to staff in the reception area and staff we spoke with were aware of this information. Staff training records indicated that the majority of staff had undergone safeguarding children training. Nursing staff and GPs received training at level 3 which met with national guidance. Administrative staff were trained at level 1. However, details were not available about the training undertaken by for one of the nursing staff and one of the administrative staff had not received child protection training, but we were told this was being arranged. In addition, apart from one nurse and two administrative staff, the majority of staff had not completed formal training in safeguarding of vulnerable adults.

Are services safe?

There was a system to highlight vulnerable patients and families on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example prompts for the GP to probe issues in more depth where there are concerns about family, including child protection issues. There were multidisciplinary team meetings fortnightly with social workers, health visitors, district nurses and a care navigator to review vulnerable patients and families. The practice was also part of the local multi-agency safeguarding hub (MASH). This provided a secure email address for sending safeguarding information to social services and enabled the practice to highlight any concerns about family members.

There was a chaperone policy, which was visible on the waiting room noticeboard but was not displayed in all consulting rooms we visited. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Nursing and some reception occasionally acted as a chaperone if nursing staff were not available. Staff had received formal chaperone training at the practice and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. However, some non-clinical staff who occasionally acted as chaperones during intimate or personal examinations had not undergone a criminal records check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. Practice staff, were aware of the action to take in the event of a potential power failure or where required temperatures were exceeded. However, we saw that some records did not reflect the action that was described to us when temperatures had gone outside the required range. Immediately after the inspection the practice raised the matter as a significant event and contacted the North West London Health Protection Team of Public Health England (PHE) for further support and advice, with reference to national guidance from PHE on vaccine storage. As a result of assurances provided by the practice, on 4 December 2014, the health protection team

determined that no further action was required in relation to the matter. Since the inspection the practice manager has shared with us the measures put in place in response to our findings.

The practice nurses were not qualified as nurse prescribers, so patient group directives (PGDs) were in place in line with legal requirements and national guidance. PGDs allow specified health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. All the necessary PGDs were signed as required and a folder was kept at the practice containing up to date directives.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions. The issue of prescriptions for anticoagulants and specific mental health medicine was dependent upon appropriate blood tests taking place.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules and written guidance to cleaners in place and cleaning records were kept. We saw the report of a comprehensive cleaning audit carried out by the practice in June 2014 and noted that the resulting action plan had been implemented. Patients we spoke with told us they always found the practice clean and hygienic and had no concerns about cleanliness or infection control. They said the clinical staff always washed their hands before and after any physical examination.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received appropriate updates. However, details were not available

Are services safe?

about the most recent training undertaken by three GPs and two of the nursing staff. Regular infection control audits took place and we were told that one had been carried out the day before our inspection but a report of the outcome was awaited. Minutes of practice meetings showed that infection control issues were discussed when appropriate.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had processes in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients, for example, a Control of Substances Hazardous to Health (COSHH) assessment carried out in February 2014 which identified the risk of legionella and the control measures in place to mitigate the risks.

Clinical waste was stored appropriately and a contract was in place for its collection and disposal.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. All equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this, for example, the annual gas boiler service completed in April 2014. All portable electrical equipment was routinely tested and we saw equipment displayed stickers and the certificate indicating the last test was dated May 2014. A schedule of testing was in place. We saw evidence of calibration testing of relevant

equipment dated February 2014; for example weighing scales, spirometers, blood pressure measuring devices, hand held ultrasound devices, pulse oximeters, ear syringes, thermometers and the vaccine fridges.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. There was a contract in place with an agency to provide locum staff and appropriate checks were completed through the agency before placing locums at the practice.

All new recruited clinical and non-clinical staff were recruited subject to a criminal records check. The practice had taken the decision not to carry out these checks for non-clinical staff who had been employed at the practice for a number of years. However, a documented risk assessment identifying and minimising any risks had not been undertaken stating the rationale for this decision.

We spoke with recently recruited staff who felt that the recruitment process had been thorough, fair and effective. They were also generally complimentary about the induction process and the practice's communication of its vision for the future based on care tailored to the local population.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice regularly monitored patient feedback and access/appointment availability and adjusted how many, when and how our clinic times would operate to ensure they matched capacity against demand. The practice used ratios provided by their accountants to ensure that the staff mix was in line with other surgeries. There were regular formal and informal meetings with staff to determine

Are services safe?

workloads and assist them to manage stress, making any adaptations that were required. The practice used occupational health services where necessary to support the practice's sickness policy and also for routine vaccinations, such as Hepatitis B.

Two members of the practice's patient participation group (PPG) we spoke with during the inspection told us they had been involved in discussions about recruitment of staff and had sat in on interviews of potential new staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. There was also a comprehensive staff instruction booklet which all staff were required to read and complete a record stating they had received instruction and understood the information provided.

The practice had a range of documented risk assessments, for example on health and safety, fire risk and exposure to infectious micro-organisms, including legionella. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the minutes of the practice meeting in July 2014 recorded the annual health and safety update, including a reminder of how to access risk assessment documentation, discussion of hand-washing and infection control, fire safety, first aid equipment and the showing of a manual handling and display screen safety.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. Patients on the mental health register were reviewed six-monthly and it was recorded on the register what action to take in the event of a crisis, including open access to a GP and

out-of-hours contact with the community psychiatric nurse. The practice monitored repeat prescribing for people receiving medication for mental ill-health and undertook reviews when repeat limits were reached.

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including access to oxygen, a pulse oximeter and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and we saw that all of the equipment was operational. We were told that monthly checks were carried out on the equipment but no record was kept of these checks to confirm this. Since the inspection the practice manager has shared with us the measures put in place to address this. Staff had received training in dealing with medical emergencies, although we noted two administrative staff were last trained in 2012 and therefore required update training to meet UK Resuscitation Council guidelines.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We were told that nursing staff regularly checked medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. However, no records were kept of the checks carried out by staff. In addition there was no system for recording and monitoring medicine stock levels. Since the inspection the practice manager has shared with us the measures put in place to address these issues.

An up to date business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included loss of the surgery building, computer system, patient records, telephone and utilities, alarm systems and incapacity of staff. It also provided contact numbers, a communication cascade, decision support tree and a command and control priority action list. In the event of major disruption to the service, the practice had access to facilities at a neighbouring practice, a nearby acute hospital and local CCG accommodation.

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The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that there were regular fire alarm tests and that they practised fire drills six-monthly. Staff received appropriate fire safety instruction and training.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs and nursing staff kept up to date with and acted on relevant professional guidance through continuing professional development, NICE guidelines, patient safety alerts and other sources such as professional journals. For example, following feedback from the GP Update network, the practice changed to non-fasting lipids for cholesterol testing based on new guidelines.

The GPs we spoke with told us they had special interests in a number of clinical areas including cryotherapy, gynaecology and joint injections. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines to support the effective assessment of patients' needs. To facilitate this, the practice held fortnightly educational meetings where clinical knowledge was shared. The practice was also introducing a daily coffee morning meeting to engage in peer review, discuss local clinical pathways and review individual patient cases.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice routinely gathered information about people's care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess performance and carried out regular clinical audit. The QOF is a national group of indicators, against which a practice scores points according to their level of achievement in the four domains of clinical, public health, quality and productivity and patient experience. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2013/14 the practice performed seven percentage points

above the CCG average for patients with asthma, but 18 percentage points above the average for chronic obstructive pulmonary disease (COPD) and 10 percentage points above for diabetes.

QOF data overall showed the practice performed above other practices in the local CCG area in 2013/2014, showing a total of 93 % of QOF points achieved in the clinical domain, which was 10% above the CCG average. For the majority of clinical indicators the practice achieved a score above the CCG average (100% in several areas) but for two indicators, dementia and depression, where they were 5% and 9% below the CCG average respectively. Action plans were in place to secure improvements in these areas. For example, for dementia, arrangements had been made for a dementia nurse to train doctors to use screening tools and they were now using the General Practitioner assessment of Cognition (GPCOG) tool for diagnosing dementia. We saw the screening template for this on the practice's computer system. Within the domains of public health, quality and productivity and patient experience, all the practice scores were above the CCG average apart from one which was equal to it.

The practice showed us six clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one of the GP team carried out a repeat audit of the use of medicine used to treat pain and inflammation associated with arthritis identified as presenting a potential risk of heart disease and stroke. The first audit led to a reduction to 33 patients being prescribed the medicine. On the second audit a year later there had been a further reduction to 17 patients, a drop of 50%.

The practice's clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, we saw an audit regarding the prescribing of a proton pump inhibitor (used to treat stomach ulcers and other conditions) for patients with osteoarthritis, rheumatoid arthritis or lower back pain. Research suggested that their long term use increased the risk of fractures related to osteoporosis. The audit identified the scope for a reduction in the number of

Are services effective?

(for example, treatment is effective)

patients prescribed the pumps. The findings were reviewed at a clinical meeting and action agreed to discuss a reduction in their use with patients concerned at their next medication review.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. Repeat prescriptions could be ordered on-line, by fax, by post, or in person at the practice. Patients were asked to allow between 24 and 48 hours for repeat prescriptions to be processed before collection. Patients with repeat prescriptions were asked to see the doctor after a total of three repeats to review whether they should continue their medication. There was an alert system on the practice's computer to identify when a review was due. Patients we spoke with felt that the on-line repeat prescription system was efficient now that some initial teething troubles had been resolved.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that in the majority of cases staff were up to date with attending mandatory courses, although information on some staff was not available at the time of the inspection. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had or had requested a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, spirometry, family planning and diabetes treatment.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. We saw on staff records that appraisal reports had been completed and staff we spoke with confirmed they had received an appraisal. This included the opportunity to discuss and agree their personal learning and development needs a personal development plan was drawn up for each member of staff.

Staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to and there were regular opportunities to discuss work matters at monthly practice meetings. We saw a sample of minutes of these meetings. We saw for example from meeting minutes that new staffing rota arrangements and building, equipment and IT issues were reviewed at a meeting in November 2014.

The practice had policies and procedures for managing poor performance but we did not see any evidence that there had been a need to activate these recently.

Working with colleagues and other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach to meet patients' needs and manage complex cases. The practice held fortnightly multidisciplinary team meetings attended by district nurses, social workers palliative care nurses and a care navigator to make and decisions about care planning. We saw from notes of these meetings that there were good records of issues discussed and action plans. We saw, for example, that the practice reviewed safeguarding concerns and raised appropriate referrals in cases where abuse was suspected. We noted also that the practice's unplanned hospital admissions register was discussed with the care navigator and discharge follow up action agreed regarding potentially vulnerable patients so that the right services were accessed and available. Paediatric care was co-ordinated with the community paediatric outreach clinic to ensure parents and their children were invited to attend the clinic when necessary.

There was an effective system in place for arranging and reporting the results of blood tests, x-rays and smear tests for example. This included a timely follow-up system to ensure these had been seen by a GP on the same day and

Are services effective?

(for example, treatment is effective)

actioned including a 'buddy' system to cover GPs in their absence. Results were usually received electronically. Patients with abnormal blood results were called in for an appointment by the GP in urgent cases.

For non-urgent medical advice out-of-hour patients were advised to call the 111 service. Patients could also visit a walk in clinic at Soho Square. The 111 service shared information about any care provided to practice patients electronically with the practice the next day. This was reviewed by the duty GP in case further action was needed.

The majority of referrals for hospital appointments were made through the 'Choose and Book' system (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice had an effective process in place to follow up patients discharged from hospital. Discharge summaries were received electronically and were followed up by a GP.

There was an in-house psychiatric nurse available at the practice on Mondays. Patients with mental health problems could book an appointment with the nurse for non-urgent counselling and advice.

The practice provided effective end of life palliative care. The practice worked closely with others to support patients receiving palliative care. There were quarterly multidisciplinary meetings with the palliative care team to review patients on the practice's end of life care register and update information about them. We saw that issues discussed included do not attempt resuscitation (DNAR) decisions and communication with out-of-hours providers. We noted that the GP's mobile telephone number was recorded on some palliative care plans for them to be called in an emergency and GPs liaised regularly with the hospice. We were told that following the death of a patient the practice reviewed the quality of care provided to identify any areas for improvement.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, information about patients on palliative care was shared with other services such as the ambulance service through the 'Co-ordinate my Care' website. Electronic systems were also in place for making referrals through the Choose and

Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. A new system had been introduced in the last year. All staff received training on the new system, and now felt competent in its use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice had an IT administrator who managed the system and advised staff on its use.

Consent to care and treatment

The practice had a consent policy which was understood and applied by staff. They confirmed they would always seek consent before giving any treatment and would make entries in patient records about consent decisions where appropriate. We saw that consent forms were available for use by clinical staff, for example for minor surgery and the fitting of coils. However, the forms were not used consistently by staff.

We found that clinical staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. However, this was an area that the practice acknowledged needed further development, especially in relation to understanding of deprivation of liberty safeguards (DOLs). Clinical staff demonstrated an understanding of Gillick competencies when asked about seeking consent. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). The review included a 30 minute GP appointment, full health screen and a medication check.

Health promotion and prevention

There was a good range of information available to patients in the waiting area which included leaflets which could be

Are services effective?

(for example, treatment is effective)

taken away from the practice. There was also relevant health promotion information in the practice leaflet and on the practice website. The website included links to the NHS Choices Website, and the most popular health subjects, including sections on family health, long term conditions and minor illnesses. The website also had a section on health campaigns, including breast awareness month, 'Be clear on cancer', and the smoking cessation campaign 'Stoptober'.

It was practice policy to offer a health check to all new patients registering with the practice. Some patients were specifically invited for a check if they had a complex health or were on repeat medicines. Risks were identified through the completion of a patient questionnaire. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept registers of all patients with a learning disability and those receiving palliative care. There was also a register for carers and carers' details were flagged in patient records. The practice offered respite care for carers and the practice's patient participation group had a support group for elderly patients who could provide support at home if needed. All patients with one or more long term conditions were proactively recalled using a computerised recall system and also opportunistically during consultations. The practice offered smoking cessation advice and support and patients could make an appointment with the practice nurse or a smoking cessation adviser.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice provided a family planning service within normal clinic times, including fitting/removal of coils and smear testing. The practice's performance for cervical smear uptake was 75%, which was 2% above the CCG average. The practice had an automatic computerised recall system for patients. Those with abnormal smears were asked to attend more frequently

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. In 2013/14 there was a 76% uptake of flu vaccination offered to patients aged 65 and older, which was above the national average of 73%. Again, there was a clear policy for following up non-attenders by two members of the administrative team by both telephone calls and in writing. Following an audit of pertussis (whooping cough) all pregnant patients had an alert in their notes to remind the GP to offer a vaccination. Health visitors screened the practice records for children who had not had pertussis vaccinations and informed the patient and their GP of this. Twenty eight percent (130 of 465) five year olds had had the vaccination. We were told that a lot of patients travelled (for example diplomat families) who were difficult to follow up for the vaccination.

The practice referred patients to the local 'MyAction' programme run by a local NHS trust. This is an integrated, nurse-led, family centred and community based cardiovascular prevention programme. For those at risk of cardiovascular disease it aimed to promote healthy lifestyle changes, reduce blood pressure and cholesterol and promote psychological well-being.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14 and a survey of 54 patients undertaken by the practice's patient participation group (PPG) in February-March 2014. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, in the national patient survey 87% of respondents rated the last GP they saw or spoke to as good at treating them with care and concern, and 97% the last nurse. Both of these ratings were above the CCG average. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 90% of practice respondents saying the GP was good at listening to them and 86% saying the GP gave them enough time. The PPG survey asked different questions but overall satisfaction was good and confirmed by 82% of patients definitely recommending the surgery to others. Respondents felt doctors were caring, patient and professional.

CQC comment cards were made available to patients at the practice area before and during the inspection so they could tell us what they thought about the practice. Unfortunately, despite encouragement from the practice staff, no cards were completed. However, we spoke with seven patients on the day of our inspection, including two members of the PPG. All but one told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us they would take patients to a private area if necessary to maintain confidentiality.

The practice had a zero tolerance policy for abuse regarding any patient who is physically or verbally abusive or threatening towards staff or other patients. The policy was on display in the reception and was also stated in the practice leaflet and on the website.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice favourably in these areas. For example, data from the national patient survey showed 91% of practice respondents said the GP involved them in care decisions, which was 14% above the CCG average. In addition 94% felt the GP was good at explaining treatment and results.

All but one of the seven patients we spoke with on the day of our inspection felt that health issues were discussed with them and they were involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that the majority of patients were able to communicate readily with them. But translation services were available for patients who did not have English as a first language. Where it was known that a patient needed an interpreter this was flagged on the patient's record. We saw also that the practice's website had a translation facility for each page in a wide choice of languages. In addition some of the clinical staff spoke other languages including Hindi, Punjabi, Urdu, Albanian and French.

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

Patient/carer support to cope emotionally with care and treatment

Are services caring?

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 87% of respondents to the patient participation group survey said the practice helped them cope very well with their health problems. The patients we spoke with on the day of our inspection and were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. One patient we spoke with who was a carer confirmed they were registered as a carer and the practice provided helpful support in this role.

The practice participated in the 'Practice Champion' scheme being piloted locally. Twelve patients had signed up for the scheme and had received training for the role. The aim was for them to voluntarily give their time to work with the staff in the practice to find new ways to improve the services that the practice offered, and to help to meet the health needs of patients and the wider community.

Patients on the palliative care register were routinely visited by their GP every two-four weeks and more frequently if their illness was terminal. The doctors and nurses worked closely with the palliative care team and district nurses to ensure palliative medicines were available when needed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The majority of patients we spoke with and felt the practice met their healthcare needs and in most respects they were happy with the service provided.

The practice engaged regularly with the local Clinical Commissioning Group (CCG) and other practices at locality meetings to discuss local needs and service improvements that needed to be prioritised. We saw locality scheme work plan the practice was signed up to which included, for example, a review of practice attendance at a range of locality scheme fora and participation in a peer review audit of outpatient referrals. We saw in this respect the practice's presentation of a review of cardiology outpatient referrals. The resulting action plan which included a recommendation to request a 24 hour electrocardiogram

(ECG) (records the rhythm and electrical activity of your heart) as a diagnostic test rather than making an outpatient referral, and to invite a cardiologist to give a talk on palpitations at a practice education meeting.

We were also shown London Area Team quality and productivity templates the practice had completed for avoidable A&E attendances and emergency admissions. These included details of improvement plans, action taken and how action taken has enabled the planned improvements to be achieved. For example, for avoidable A&E attendances, the practice action included the extension of its walk in clinics to three mornings a week so patients knew they would be seen urgently and promptly; and continued review of A&E attendance and calling in repeat attenders to discuss their care with them. No discernible patterns of re-attendance were evident from data reviewed but the practice identified two patients who were regular attenders who were referred to the community matron.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Respondents had previously

asked for an extra walk-in clinic which was now available on Mondays. They had also asked for self-care health advice to be provided and this was now available on the website with links to a range of information and guidance.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, although for urgent appointments this was not always possible. In the national patient survey 2013/14 the practice scored 70% for patients with a preferred GP who usually get to see or speak to that GP. This was 12% above the CCG average. If a patient requested a preferred GP and there were no appointments available on the day, the GP would phone the patient at the end of the morning or afternoon clinic. The practice had one male and five female GPs and a two female and one male locum, so was able to offer some choice of male or female doctor if this was requested.

Each patient over 75 had a named GP. They also had care plans which were added to and amended as circumstances changed. For older patients and patients with long term conditions home visits were available.

The practice provided antenatal care during normal surgery times and a baby clinic twice weekly with health visitors. Separate family planning was also provided in normal surgery times. Minor surgery was provided at the end of surgery sessions. A wart clinic was held twice monthly. The practice offered well person checks to discuss lifestyle and advise patients on ways to minimise health risk factors.

Patients with diabetes were referred to the local community diabetic clinic. The needs of new diagnosed patients were reviewed and referred to appropriate education programme, a dietician and eye screening.

Services were available in the community for patients with drug dependency and alcohol problems. The practice referred patients to these services or patients could self-refer.

The practice previously ran dedicated specialist clinics for patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes and hypertension. However, these were not popular with patients and the practice now provided services to these patients in normal clinic times.

Are services responsive to people's needs?

(for example, to feedback?)

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was an open door policy and vulnerable groups such as the homeless could receive treatment. Street sex workers and drug users were referred to appropriate services locally.

The practice had access to online and telephone translation services and some of the clinical staff spoke different languages.

The practice had an equality and diversity policy. Staff read the policy as part of the induction process and were aware of patients' equality and diversity needs covering a diverse population of patients. However, they had not received specific equality and diversity training.

The premises and services had been subject to a disability audit and adapted to meet the needs of patient with disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was an induction loop in place for patients with impaired hearing.

The practice was situated on the ground and first floors of the building with services for patients on both floors. There was no lift access to the first floor and if patients were not able to use the stairs, they were seen in a consulting room on the ground floor.

Access to the service

Appointments were available from 08:00 to 11:30 and 14:00 to 19:00 on Monday and Tuesday; 08:00 to 12:30 and 14:00 to 17:00 Wednesday and Thursday and 07:00 to 11:30 and 14:00 to 17:30 on Friday. The practice also ran a walk-in clinic on Monday, Tuesday and Friday mornings from 10.30 to 11.30 for any patient with an urgent need for a same-day appointment. Routine appointments of 10 minutes were available within a maximum of two days. If patients were unsure about the seriousness of their problem they were advised to ask to speak to the doctor or nurse. If the

problem was likely to be complex they were advised to ask the receptionist to book a double appointment. If patients needed telephone advice, they were advised to ring the surgery between 12.30 and 14:30. The practice also sent out text message reminders of appointments to patients with a mobile phone number. Five of the seven patients we spoke with confirmed they received text reminders.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the NHS 111 out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions for whom there were alerts on the computer system when staff booked appointments. This also included appointments with a named GP or nurse.

Patients we spoke with were generally satisfied with the appointments system. One mentioned that sometimes there was a delay in getting through on the telephone and sometimes they had to wait to go into an appointment but not usually for very long. Another told us that there is rarely an excessive delay in obtaining an appointment and they found it very to make an appointment. All patients we spoke with felt that the on line booking system was efficient now that some initial teething troubles had been resolved.

Data from the 2013/14 national GP patient survey showed 85% of respondents said they were able to get an appointment to see or speak to someone the last time they tried, which was 2% above the CCG average. Ninety six percent said their last appointment was convenient and 91% described their experience of making an appointment as good. Sixty five percent of respondents said they usually wait 15 minutes or less after their appointment time to be seen, which was 7% above the CCG average. Seventy percent of respondents with a preferred GP said they usually got to see or speak to that GP (12% above the CCG average). Eighty percent were satisfied with the surgery's opening hours (4% above the CCG average).

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The complaints procedure included reference to the organisations with which the complainant could pursue matters further if they were dissatisfied with the handling of their complaint, NHS England and the Ombudsman.

We saw that information was available to help patients understand the complaints system. There was a comments box in the reception area where patients could make suggestions or comments. There was also information about making complaints in the practice leaflet and on the practice website, including a complaint leaflet and form which we were shown. Five of the seven patients we spoke with were aware of the complaints procedure but none had made a complaint about the practice. One patient told us of concerns they had had about the attitude of member of staff but had raised this directly with the practice manager who had dealt with the matter without the need to make a formal complaint.

We were provided with an analysis of complaints received in the last two years which included a summary of the complaint, action taken, the response and action plan and the forum where it was discussed within the practice. Staff we spoke with understood the complaints procedure and confirmed that any learning from complaints was discussed with them. Complaints were a standing item on the agenda on practice meetings and we saw in the minutes of the meeting in May 2014 there was an annual review of complaints and significant events.

We looked at the 10 complaints received in the last two years. We saw that these were dealt with in a timely manner, and the response offered an appropriate explanation and apology. Lessons learned were communicated within the practice. For example, as a result of a complaint about a delayed referral, we saw the email to staff setting out the revised process for dealing with two week waiting cancer referrals faxes to ensure they have been received by the hospital. We noted also that the practice identified themes and trends in its annual review of complaints. We saw that appropriate action was taken regarding a number of complaints about the attitude and manner of a member of staff.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice aims were stated in the practice leaflet and on the practice website and emphasised the focus on helping patients maintain good health rather than simply to treat them when they were ill. Importance was placed on team work between doctors, nurses, health visitors and counsellors and links to community based psychiatric teams, other support teams drug dependency groups, alcohol support services and social services. From speaking with staff, the practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service. The practice was proud of its person centred, family orientated and 'village doctor' approach to the service and encouraged staff to take time to get to know the patients and their families. Patients we spoke with valued this and the practice felt it reaped the benefits of the approach of knowing patients so well, for example in keeping A&E attendances at relatively low levels.

The practice reviewed its strategy periodically and we saw from the agenda of a strategy meeting in October 2014 that the practice was evaluating the efficiency and effectiveness of its staffing mix and responsibilities and systems and procedures. Specific proposals included the recruitment of a phlebotomist for a daily morning walk in service and an assistant practice manager, the expansion of the practice secretary role and a review of organisational activities and the assignment of new roles. Some of these initiatives were in the process of being implemented at the time of the inspection.

Governance arrangements

The practice had a comprehensive range of policies and procedures in place to govern activity and these were available to staff via the computer system within the practice. There was a staff handbook containing appropriate human resource policies. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff. The policies were subject to regular review and updating, although we noted that some policies were overdue a review.

There was a clear leadership structure with named members of staff in lead roles. For example, there were GP

leads for consent, safeguarding and IT. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data showed the practice performed above other practices in the local CCG area for the majority of indicators in the year ending April 2014. We were told that QOF data was regularly discussed at clinical team meetings and action planning put in place to maintain or improve outcomes. Some fortnightly education meetings dealt solely with QOF. The IT administrator provided monthly progress reports to identify areas for improvement and current values were compared to the previous year's. Dedicated clinics were run to address improvements. For example, for rheumatoid arthritis, following an action plan agreed at a QOF meeting.

The practice told us about a local peer review system they took part in to benchmark services with neighbouring GP practices. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, CCG data showed that between April 2013 and March 2014 the annual A&E attendance rate for the practice was below the CCG average for all attendances and also for non-elective admissions.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, in July 2014 the practice completed a medicines harm audit of patients on oral anti-coagulants who had an international normalisation ratio (INR) within an acceptable range. INR is a measure used to test how well anti-coagulants are working. As a result of the audit which found that the standards for the INR were being met for patients audited, the GP placed a limit on the number of repeat prescription requests for these patients to motivate them to attend for an INR check and ensure correct prescribing.

The practice had arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, there were regular health and safety and fire risk

Are services well-led?

Good 

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

assessments of the practice environment and equipment. The practice also regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly.

The practice had an ongoing programme of regular governance meetings. These included alternating weekly clinical and education meetings and monthly all practice staff meetings. All of these meetings were formally minuted and, from the small sample of minutes we saw, we found that performance, quality, risks and operational issues had been discussed.

Leadership, openness and transparency

We saw from minutes that 'all practice' meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy, disciplinary procedures, and the management of sickness, which were in place to support staff. There were a wide range of other policies including equality and diversity, prevention of harassment and learning training and development.

The practice acknowledged that changes in the practice with the departure of a GP partner had caused some disruption. Many patients had been upset by this and needed support to adjust to going to a different GP. However, practice managers felt that despite a difficult few months, the new staffing strategy recently put in place and the establishment of more efficient and effective ways of working provided a strong base for the future.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) which included representatives whose main spoken language was English and the majority were 'White' or 'White British' by ethnicity. Every attempt was being made by the PPG and practice to ensure the PPG was representative of the profile of the patients of the practice. This included providing information to all new patients registering with the practice.

The two members of the PPG we spoke with told us the surgery opening hours had been changed in response to patient survey results. The introduction of walk-in clinics had proved particularly popular. Saturday morning opening had also been indicated as potentially useful on the annual patient survey and we were told discussions had taken place with practice manager regarding this. However it was decided at the time that this was not possible in light of funding and budgetary constraints. We noted from the 2014 PPG report that other issues raised about the appointment system included difficulty in getting to speak to a GP on the telephone and waiting times for consultations to start. These issues were being taken forward in the PPG action, although waiting times were acknowledged ongoing problem both the PPG and practice had been working on together for some time with no obvious solution.

The practice had gathered feedback from staff through staff meetings, appraisals and ongoing day to day discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents which included lessons learned. Specific meetings were held to review significant events and complaints and identify areas to improve outcomes for patients. For example, following a prescribing error, the incident was reviewed at a clinical meeting and action agreed to review the matter with the GP for personal development, provide further training on the patient information system to avoid future errors. The incident and lessons learned were also communicated to other staff for learning.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>Patients were not sufficiently protected against the risks associated with unsafe use or management of medicines because there was no system for recording and monitoring emergency medicine stock levels. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>Patients were not were not fully protected from the risks of unsafe or inappropriate care and treatment because training records about staff employed to carry out the regulated activities relating to infection control and safeguarding of children were not always accurately maintained. This was in breach of regulation 20(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>