Dr Maher Shakarchi

Quality Report

Belgrave Medical Centre
13-13A Pimlico Road
London
SW1W 8NA
Tel: 020 7824 8827
Website: www.victoriagp.com

Date of inspection visit: 10 December 2014
Date of publication: 14/05/2015

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Maher Shakarchi on 10 December 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective and well-led services. It also required improvement for providing services for the 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). It was good for providing a caring and responsive service.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Data showed patient outcomes were at or above average for the locality.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments usually available the same day.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice held regular practice and clinical meetings.
- Access to the service was very good with extended opening hours and longer appointments for patients where needed.
- The practice was proactive in seeking and responding to patient feedback.

The areas where the provider must make improvements are:

Summary of findings

- Ensure equipment is properly maintained and suitable for it's purpose.
- Ensure lessons learnt from significant events are shared with all relevant staff.
- Ensure clinical audit cycles are completed and are used to drive improvements in patient care.
- Ensure that all at risk patients are suitably identified and their records accessible to all relevant staff.
- Ensure all staff receive safeguarding vulnerable adults training.

In addition the provider should:

- Ensure care plans are fully completed
- Ensure a Legionella risk assessment is undertaken.
- Ensure all staff who act as a chaperone to patients are suitably trained.
- Ensure there is a back-up system for the diversion of the telephone line should the practice experience a power cut.
- Ensure there is a coordinated approach of the fire procedure with other's who share the building.
- Ensure there is evidence to demonstrate that any person making a decision on behalf of a patient who lacks capacity, has the legal right to do so.
- Ensure formal arrangements are in place for access and use of an automated external defibrillator (AED).

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed but not always shared with relevant staff. There were enough staff to keep patients safe. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt but not always communicated to all staff to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or above average for the locality. 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. This included assessing capacity and promoting good health. The practice had not completed any two cycle clinical audits and were unable to demonstrate that clinical audits were driving improvement in performance to improve patient outcomes. Staff had received some training but not all considered appropriate to their roles. There was evidence of appraisals and some personal development plans for staff. Staff worked with multidisciplinary teams and shared information with other services as appropriate.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients who completed our CQC patient comment cards and who spoke with us on the day of the inspection visit were very complimentary about the service they received. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a clear vision and strategy which staff were of and knew their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. Not all staff however were made aware of essential information.

There were systems in place to monitor and improve quality and identify risk, however not all risks had been addressed and clinical audits were not used seen to be used to drive improvement. There was an active patient participation group (PPG) and the practice was proactive in seeking and acting on feedback from patients and staff. Staff had received inductions, regular performance reviews and attended staff meetings.

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

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The majority of registered patients at the practice were of working age. The practice provided extended opening hours on a Saturday between 10am and 1pm which were particularly useful to patients with work commitments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. However there was no evidence that patients with a learning disability had received an annual health check. The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Patients experiencing poor mental health were offered an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health

Summary of findings

about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We received 25 completed Care Quality Commission (CQC) comment cards and spoke with eight patients on the day of our visit. All patients were positive about the service they received.

Patients told us they felt clinical staff were professional and very caring and administrative and reception staff were very polite and helpful.

Patients confirmed consent was always sought by clinical staff before undertaking a physical examination or treatment and all consultations and treatments were carried out in the privacy of a consulting or treatment room. Patients were aware of their right to a chaperone.

Patients said they were always able to get an appointment when they needed one and felt GPs and nurse were good at explaining their treatment and involved them in making decisions about their own care. Patients also told us that the repeat prescription process worked well and opening times were extremely convenient.

Data from NHS Choices showed 81% of patients said they would recommend the practice.

All patients who completed our CQC patient comment cards felt they were given sufficient information by the doctor or nurse in an accessible format regarding their condition. Patients said they felt involved in making a choice about their treatment options.

Areas for improvement

Action the service MUST take to improve

- Ensure equipment is properly maintained and suitable for it's purpose.
- Ensure lessons learnt from significant events are shared with all relevant staff.
- Ensure clinical audit cycles are completed and are used to drive improvements in patient care.
- Ensure that all at risk patients are suitably identified and their records accessible to all relevant staff.
- Ensure all staff receive safeguarding vulnerable adults training.

Action the service SHOULD take to improve

- Ensure care plans are fully completed
- Ensure a Legionella risk assessment is undertaken.
- Ensure all staff who act as a chaperone to patients are suitably trained.
- Ensure there is a back-up system for the diversion of the telephone line should the practice experience a power cut.
- Ensure there is a coordinated approach of the fire procedure with other's who share the building.
- Ensure there is evidence to demonstrate that any person making a decision on behalf of a patient who lacks capacity, has the legal right to do so.
- Ensure formal arrangements are in place for access and use of an automated external defibrillator (AED).

Dr Maher Shakarchi

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 advisor and an Expert by Experience who are not independent individuals, they accompany an inspection team and are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Maher Shakarchi

Dr Maher Shakarchi is a single location practice which provides primary medical services through a Primary Medical Services (PMS) contract to approximately 3,700 registered patients. The practice is one of 37 practices operating in the Central London Westminster Clinical Commissioning Group (CCG). The patient population groups served by the practice include a cross-section of socio-economic and ethnic groups. There is a transient patient population of approximately 50 patients joining and leaving the practice each month.

The practice team was made up of a full time (male) GP who provided 11 sessions a week , a part-time (female) sessional assistant GP who provided two sessions a week over 10 hours and a full-time (female) practice nurse who worked 37.5 hours a week. The team also included a part-time practice manager who worked 20 hours a week, a receptionist and an administrator / receptionist.

Dr Maher Shakarchi provides the regulated activities; Diagnostic and screening procedures, Treatment of disease, disorder or injury, Family planning, Maternity and midwifery services, and Surgical procedures.

The practice is open and appointments can be made between:

7:30am – 8pm Monday & Wednesday

7:30am – 6:30pm Tuesday, Thursday & Friday

10am – 12:45pm Saturday

The practice does not close for lunch and patients can arrange to speak with the GP at 12noon and 3pm each weekday.

Extended hours operate Monday & Wednesday evenings and Saturday mornings.

Dr Maher Shakarchi does not provide an out-of-hours service.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 December 2014. During our visit we spoke with a range of staff, two GP's, a practice nurse, the practice manager, one receptionist and one receptionist / administrator and spoke with patients who used the service. 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 CQC patient comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

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. We saw the practice had responded appropriately to an alert regarding a particular medication issued in April 2014 where a patient list had been drawn up and the effected patients had been contacted by either the GP or practice nurse.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two 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. 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.

We looked at the records of significant events and saw evidence of appropriate action which had been taken by the principal GP as a result a delayed cancer diagnosis. Although significant event information could be accessed via the practice intranet not all staff we spoke with were aware of all which had taken place. Significant events were not discussed as a standing item on the practice meeting agenda and although the principal GP was able to evidence that they had learnt from significant events, they were unable to demonstrate that the findings had been shared with all relevant staff.

The practice meeting minutes evidenced that complaints were discussed and used by the practice to support learning. We were told by the principal GP that national patient safety alerts were received electronically and filed in an alerts folder. These were discussed as they were received and a clinical decision was made by the GP as to what action was needed. We were given an example of increased cardiovascular risks identified with the prescribing of a particular medicine. The practice undertook a search for patients who were on this particular medicine following the alert and where appropriate had discontinued or given an alternative medicine. We were told that particular medicine was now only prescribed by the GPs for short courses.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. Training records evidenced that clinical staff had received Level 3 and non-clinical staff Level 1 safeguarding children training, however staff had not received any formal training in safeguarding vulnerable adults. All staff were aware of their responsibilities to report any concerns to the principal GP or practice nurse and knew how to share information in their absence.

The principal GP was the appointed lead for both safeguarding vulnerable adults and children and held relevant contact details to report a safeguarding children's concern. The GP told us that they liaised with the community health visitor and other clinical staff within the practice when they received information regarding a child's safety.

We were shown the minutes from the last child protection case conference attended by the principal GP six months earlier. We were told that the GP would complete reports for child protection case conferences where they were unable to attend in person.

Although the principal GP was aware of which patients were considered vulnerable and why, they did not have an adequate system set up to record or highlight these to all other clinical staff who may need to know this information in their absence. For example, the principal GP held a list of those children who had been referred to the children at risk register. This information however had not been recorded on the patient notes in a way that would flag any concerns. In addition we found that the minutes to a child protection case conference filed separate to the patient's records, with no alert added. We discussed this with the principal GP who understood the importance of sharing this information and said they would ensure an alert system was implemented.

Requires improvement

Are services safe?

There was a chaperone policy and staff were aware of a patients right to have a chaperone. The principal GP said the practice nurse and reception staff acted as a chaperone. Where this was not possible due to staff availability a patient could arrange their own chaperone or would be offered the opportunity to be seen by an alternative clinician. Although reception staff had not received any formal training they understood the principles of chaperoning, including where to stand to be able to observe the examination. Non-clinical staff said patients were encouraged to ask for a chaperone when making an appointment but there was no information on display to inform a patient of this. We noted that all staff who acted as a chaperpone had a Disclosure and Barring Service (DBS) check in place.

The principal GP said the practice was automatically notified by letter of any child or young person who had attended A&E more than twice in two months. These patients were then contacted by the GP for follow-up.

The nurse had an appropriate system to follow up on children who persistently failed to attend appointments e.g. for childhood immunisations.

The practice had a system for reviewing repeat medications for patients with co-morbidities and on multiple medications, every six months.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example; anxiolytics and hypnotics.

The nurse administered vaccines and childhood immunisations using directions that had been produced in line with legal requirements and national guidance. The nurse was aware of when to consult the Patient Group Directions (PGDs) (a set of specific written instructions for the supply and administration of a licensed named medicine to specific group of patients).

We were told that patients on high risk medicines received regular monitoring through the local hospital. The practice nurse was aware of possible contraindications (specific situations in which a drug, procedure, or surgery should not be used because it may be harmful to the patient) and where risks were identified these were discussed with a GP.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We were told that repeat prescriptions were reviewed annually or where needed six monthly. The practice used an electronic repeat prescription system which would not allow a prescription to be issued without a GP authorisation.

We were told there were no controlled drugs held by the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control. The most recent infection control audit dated October 2014 had been completed in conjunction with the Clinical Commissioning Group (CCG) infection prevention/health protection advisor. Improvements had been identified and action points had been set. The practice assured us they were working towards completing these actions within the agreed timescales. Minutes of practice meetings showed that cleanliness and the findings of the clinical audit had been discussed.

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; the use of personal protective equipment, the handling of specimens and responding to a needle stick 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.

Requires improvement

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). Although we saw a policy in place, the practice had not undertaken any checks as indicated in the policy to reduce the risk of infection to staff and patients. We were told that this needed to be negotiated with the other GP practice which shared the premises. We noted that there was no risk assessment in place and legionella testing had not been included in either the building risk assessment or the infection control audit.

Equipment

Staff we spoke with told us they had relevant equipment to enable them to carry out diagnostic examinations, assessments and treatments. Although a schedule of testing was in place the calibration of relevant equipment; for example the weighing scales, spirometer, nebuliser and pulse oximeter this had not been undertaken as required in March 2014. The principal GP told us this was due to financial constraints, however they understood the importance of this and assured us this was would be prioritised.

Although some equipment had been tested and maintained regularly as part of the building risk assessment, such as the gas and electrical supply, boiler, firefighting equipment and alarm system, others were overdue such as the annual testing of portable electrical equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff records indicated that all relevant pre-employment checks such as proof of identification, references and a criminal record check had not been undertaken prior to the employment. However, all staff had been employed prior to the practice's registration with the Care Quality Commission (CQC) and although good practice, was not a legal requirement at the time of their employment.

We noted that all staff currently employed at the practice had a Disclosure and Barring Service (DBS) check in place.

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. We were told there was a system in place for the reception/ administration staff to cover each other's annual leave and locums were used where needed.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Risks were identified and mitigating actions recorded to reduce and manage the risk. Risks identified through the infection control audit and building risk assessment were discussed at practice meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. The practice used 'Coordinate my care' for patients receiving palliative care. (Coordinate my care is a system for recording patients' wishes regarding their care which is electronically available to other appropriate care services).

The practice said they were piloting the D-Dimer test (a fingertip blood test) to assess the risk of deep vein thrombosis (DVT).

The practice had a proactive recall system for all patients with long-term conditions. They offered longer appointments and an annual review as standard practice. The practice also used the risk stratification tool from Wellwatch as part of a pilot scheme (a means of identifying at risk patients, offering appropriate interventions through collaborative working).

The practice responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. We were told that the practice had good access to a local assessment service and the brief treatment team (ABT) for general referrals and could make urgent referrals to the duty psychiatrist at the local hospital. The practice monitored repeat prescribing for people receiving medication for mental ill-health, including flagging up any overdue medication which has not been requested by the patient or pharmacist.

Arrangements to deal with emergencies and major incidents

Requires improvement

Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in Cardiopulmonary Resuscitation (CPR) and basic life support on 01/10/2013 which meant clinical staff were overdue their annual refresher training. Emergency equipment available included access to oxygen and first aid kits. A certificate was available for inspection to evidence that the oxygen cylinder had last been serviced on 31/01/14.

The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and although there was no risk assessment in place the principal GP said the emergency services would be called should there be a need. We were told there was access to a defibrillator via the other practice which shared the building however there was no agreement in place that this could be used by the provider in an emergency. Not all staff we spoke with were clear what emergency equipment was available or where this was held. The nurse told us that they were responsible for checking the first aid equipment and emergency drugs. We checked these and found them to be well organised and all in date.

Emergency medicines such as those for the treatment of anaphylaxis were available in a secure area of the practice. The practice nurse took responsibility for checking these medicines were within their expiry date, suitable for use, held safely and replenished when needed. In the absence of the practice nurse the principal GP took responsibility for emergency medicines. All staff were aware of where these medicines were held.

A business continuity plan dated December 2014 which covered all expected areas to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of power, limited access to the building and continuity of care. We noted however there was no back-up system for the diversion of the telephone line should the practice experience a power cut and the practice did not print a daily patient list should they need to make contact with patients in an emergency. We discussed this with the principal GP who said they would add this into their business continuity plan.

The practice had an appropriate fire procedure. Training records showed that the designated fire marshal had undertaken relevant fire marshal training however other staff had not received any specific training other than an annual fire drill organised by the fire marshal. Staff spoken with were aware of the fire evacuation procedure and their responsibilities to encourage patients to evacuate the building. However there was a need to coordinate the evacuation procedure with the other GP practice who shared the building as currently both practices operated their fire procedure separately.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and practice nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and the nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

There were appointed leads for both clinical and non-clinical areas of the practice. The principal GP took the lead in areas such as risk management, safeguarding, medicines management and minor surgery, whilst the practice nurse led in infection control, childhood immunisations and women and children health. Other areas were delegated to the sessional GP, practice manager and receptionist/administrator. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened.

We looked at data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

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. An equality and diversity protocol was accessible to staff in an electronic format via their intranet.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice also used the information collected for the quality and outcomes framework (QOF), a national performance measurement tool, to monitor outcomes for patients. For example, 94% of patients with diabetes had received a foot examination, and the practice met all the minimum standards for QOF in diabetes/asthma/mental health and coronary heart disease (CHD). This practice had been identified as being below the expected prevalence for the identification of chronic obstructive pulmonary disease (lung disease) however the principal GP explained this was due to the lower than average patient population for over 65 year olds.

Staff used audit, clinical supervision and staff meetings to assess their performance. The staff we spoke with discussed how, as a group, they reflected on the patient outcomes being achieved and areas where this could be improved. Staff were positive about the culture in the practice around audit and quality improvement and told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. We were shown various prescribing audits which had been undertaken within the past two years. Although these included identified actions, they had not been revisited and were therefore not full two cycle audits and improvement in patient care had not been evidenced.

There was a protocol for repeat prescribing which was in line with national guidance. The practice used an electronic repeat prescription system which would not allow a prescription to be issued without a GP review/ authorisation. Staff checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice held register of those patients in receipt of end of life care and participated in regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Requires improvement

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were not all up to date with all mandatory courses such as annual basic life support and safeguarding vulnerable adults. Both GPs were up to date with their yearly continuing professional development requirements. One GP had been revalidated in November 2014 and one was due for revalidation in February 2015 (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by General Medical Council can the GP continue to practise and remain on the performers list with the NHS England).

The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, childhood immunisations and family planning.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that they felt supported in their role. The practice nurse said they had recently been sponsored by the principal GP to undertake a nurse prescriber course.

Staff files we reviewed showed that all staff had received annual appraisals to support their development.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Information such as blood test results, X-ray results, and letters such as discharge summaries from the local hospital were shared electronically or by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. We were told that there were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held regular monthly multidisciplinary team meetings with the district nurse and three monthly meetings with the palliative care nurse both of whom were attached to the practice to support and discuss the needs of complex patients such as those with end of life care needs or children on the at risk register. Staff told us they also liaised regularly with other health care professionals such as health visitors and the community psychiatric nurse. We were told that the practice also worked with midwifery services for shared antenatal care and provided a weekly baby clinic. Staff at the practice felt these meeting worked well, allowing them to share and receive information regarding a patient's treatment and care. Although the principal GP was able to show us where these meetings had taken place and a record had been made in the patient notes, this had not been formalised into a care plan.

Information sharing

The practice received information from out-of-hours GP services and the 111 service both electronically and by post. This shared system with the local GP out-of-hours provider enabled patient data to be shared in a secure and timely manner. Patients with spoke with knew how to contact the out of hours GP and those which had used them felt the process of information sharing had worked well.

Electronic systems were also in place for making referrals to other healthcare providers. Patients who required referral could use the Choose and Book system (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions.

The principal GP told us that they used national standards for the referral of patients with suspected cancers referred and seen within two weeks (known as the two-week wait pathway). We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. We saw evidence on staff files that staff had received some training on the system and had further

training arranged. Staff commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We were told and saw information on the practice website that the practice was working to enable summary care records (these contain a patient's key health information and can be accessed by authorised healthcare staff in A&E departments).

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation, however we were told about one patient who lacked capacity who's care was decided by a family member. It was unclear if this person had the legal right to make these decisions as there was no written evidence available to support this.

The principal GP said that they involved carers where possible should dementia be suspected in older patients.

The principal GP told us that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. Although the principal GP was able to show us that relevant information had been recorded in the patient notes, they were unable to show us evidence of a fully completed care plan for any patient.

There was a practice policy for documenting consent and the withdrawal of consent which included forms for completion by the clinician and patient. The policy also covered consent for people attending with carers and the assessment of a young person's capacity to understand a procedure and give their consent (Gillick Competence). Verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. A patient's written consent was required for all immunisations and minor surgical procedures

Health promotion and prevention

The practice said they fully engaged NHS England and the CCG to discuss the implications and share information about the needs of the practice population.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The nurse used their contact with patients to help maintain or improve mental, physical health and wellbeing by offering smoking cessation advice to smokers, well women's health checks and family planning-contraception advice. The practice told us they sent about 70 invite letters a month to patients aged 40-75 to attend an NHS Health Check and received a 36% take up.

The practice identified the smoking status of patients over the age of 16. We were told that the practice nurse offered opportunistic help and advice to those patients who smoked. In addition the practice held a smoking cessation clinic once a week in conjunction with kick-it a stop smoking service.

The practice had identified patients who needed additional support and the principal GP held lists of those patients with a learning disability and a diagnosis of dementia. Although these patients had been identified they had not all been offered annual health checks and although relevant information had been recorded on their patient record, they did not have a fully completed care plan.

The practice held an end of life care register. We were told that the principal GP took part in monthly meetings with the community nurse and the practice nurse attended quarterly palliative care meetings with the district nurse. The practice used coordinate my care to coordinate information with out of hours services, ambulance and hospital services.

The practice's performance for cervical smear uptake was 68% which was slightly worse than others in the CCG area. The practice recognised the need to increase their cervical smear take up and the practice nurse who had a particular interest in this area told us that they had developed a technique which enabled women to have more control over the process. Invitation letters were sent by the practice to all eligible women in addition to the invite letters sent by the local Health Authority. The practice had also initiated a recall system for a six month period, to telephone eligible patients to invite them for screening. The practice nurse was the clinical lead for cervical smear testing and was responsible for actioning abnormal test results and the follow up of patients who did not attend screening.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice nurse was the clinical lead for childhood immunisations and was responsible for the follow up of any non-attenders and liaising with the health visitor each week.

We were told by the principal GP that older patients, all those over the age of 75 had a named GP and a care plan. We were told that the 'village' network made up of four similar practices, enabled GPs to discuss patient care needs with colleagues and other service providers who attended these meetings, such as social services and environmental health. GPs used the General Practitioner assessment of Cognition (GPCOG) tool (a screening tool for cognitive impairment) where they suspected dementia in older patients and referrals were made to the local memory clinic. Data available showed 83% of patients diagnosed with dementia had had a face to face review, which was comparable with other practices in the local area.

The practice had good access to a counsellor and psychological therapist who were based at the practice twos day a week. Patients with poor mental health were signposted to the local MIND and SANE support groups and younger patients were referred to the Child and Adolescent Mental Health Services (CAHMS).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The national patient survey showed the practice was rated above the regional CCG average for access, including getting through on the telephone, opening hours and making an appointment. The practice was also 33% above the regional average for those patients who usually wait 15 minutes or less after their appointment time to be seen and 21% above the regional average for those patients who get to speak to or see a GP of their choice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards all of which were positive about the service experienced. 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. We also spoke with eight patients on the day of our inspection. All 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 the GP treatment room 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.

Despite there being a shared reception and waiting area we saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Receptionist staff told us that they had not received any specific training in working with difficult or aggressive patients but felt confident in being able to diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed 76% of patients felt involved in planning and making decisions about their care, however only 73% of patients felt the GP was good at explaining treatment and results which was 7% below the regional CCG average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Although the practice had identified vulnerable patients and those with complex needs and relevant information had been recorded on the patient notes, there were no fully completed care plans available for inspection.

Patient/carer support to cope emotionally with care and treatment

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, 90% of respondents to the national patient survey said the GP they saw or spoke to was good at listening to them. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice provided patient's with information leaflets regarding condition detection, symptoms management and support organisations, including signposting to alternative care resources, mental health support, disease prevention and adopting a healthier lifestyle.

Staff told us that if families had suffered bereavement, the GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

We were told that women, who were known to have had a complicated pregnancy such as a miscarriage or still birth, were offered counselling and given additional support in their next pregnancy.

Good

Are services caring?

Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. We were told by one patient that they had been referred for counselling following a bereavement which they had found very helpful.

The practice told us that they had good access to a palliative care nurse at a local hospice who they felt were effective at assisting people in managing their conditions.

Good

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

We were told that the practice met with the Clinical Commissioning Group (CCG) every month to discuss local needs and service improvements that needed to be prioritised. In addition to these meetings the practice was also part of a 'Village' network, working with other local GP practices to ensure patients received appropriate multidisciplinary care and treatment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

We were told that many languages such as Arabic, French, Portuguese, Spanish, Bengali and Hindi were spoken within the staff team. Staff told us that they had access to an online interpreting service if needed.

The practice was situated on the ground and lower ground floors of the building with most services for patients on the ground floor. There was no lift access to the lower ground floor but there was a disabled toilet and an examination and consultation room available on the ground floor for those patients with restricted mobility or wheelchair users.

We saw that the ground floor waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 7:30am to 8pm Monday and Wednesday, 7:30am to 6:30pm Tuesday, Thursday and Friday and 10am to 12:45pm on a Saturday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. Out of hours was covered by an out of hours provider or 111 services. Urgent appointments were available same day and general appointments were available from 7:30am – 8pm Monday & Wednesday and 7:30am – 6:30pm Tuesday, Thursday & Friday.

Patients confirmed that they could see a doctor on the same day if they needed to and felt access to the practice was good.

The practice's extended opening hours on a Saturday between 10am and 1pm were particularly useful to patients with work commitments. We were told that 79.5% of patients were between the ages of 16 and 64.

Appointments were available outside of school hours for families, children and young people. Staff told us that home visits were available where needed, in particular for older people with a view to minimising hospital admissions. Longer appointments were available where needed in particular for patients with learning difficulties or those with long term conditions. Where appropriate online or telephone consultations where offered every week day between 12noon and 3pm to enable people to return to work and an online booking system was available. We were told that text message reminders were sent to patients for appointments and test results.

The principal GP told us that homeless people and travellers were occasionally seen as temporary patients and were signposted to local specialist services, which included an outreach doctor and nurse service. Patients with alcohol or drug addiction were also seen but this was as a brief intervention. as they would then be signposted to a specialist drugs and alcohol service for Westminster residents.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in place. A poster was displayed on the main noticeboard at reception and in the waiting area on the lower ground floor. The patient information leaflet and practice website gave information

Good

Are services responsive to people's needs?

(for example, to feedback?)

on how to make a complaint. All of the patients we spoke with said they were very happy with the service they received and had never needed to make a complaint about the practice.

We looked at the two complaints received in the last 12 months and found these had been dealt with in a timely manner and where appropriate learning from these had been identified.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice stated that they aimed to provide a welcoming, listening and responsive service to all patients. Promote staff development through teaching, research and training and maintain financial stability by optimising income, relating costs to benefits to both patients and staff and generally seeking value for money. Despite having a clear vision there was no formal business plan in place to ensure the practice would deliver a sustainable service.

Staff we spoke with were aware of and understood the practice vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Most policies and procedures had last been updated in October 2012 and had not been reviewed since then.

There was a clear leadership structure with named members of staff in lead roles.

We spoke with six 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. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Evidence was seen in practice team meeting minutes that issues were discussed and changes were made to the operations of the practice to resolve issues. For example the practice's cleaning provider was changed when they did not meet infection control requirements. This was discussed at the next team meeting and the improvements to cleaning noted.

The practice undertook audits such as infection control and prescribing to monitor quality and systems to identify where action should be taken. There was no evidence that clinical audits were used to drive improvements in patient care.

The practice had arrangements for identifying, recording and managing risks. Risk assessments such as a building risk assessment and an infection control audit had been carried out where risks were identified and action plans had been produced, discussed at practice meetings and updated in a timely way. However, not all risk had been identified and addressed, such as ensuring they could respond appropriately to medical emergencies.

Staff said they discussed governance in their monthly practice meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment and induction policy, which were in place to support staff. All policies and procedures were available to staff electronically and staff we spoke with knew where to find these if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active Patient Participation Group (PPG). The practice website gave information about the PPG and the annual patient survey could be reviewed. The practice had drawn up an action plan to address areas for improvement which had been highlighted in the last PPG survey. These included increasing the availability of the female GP, improving access to information through the practice website and further access to extended hours.

The practice also used the GP patient survey to identify the areas where they were doing well and where improvements could be made. Data from the latest GP patient survey

Are services well-led?

Requires improvement

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

recorded 95% of patients found it easy to get through on the telephone, 89% were able to get an appointment to see or speak to someone the last time they tried and 90% said the last GP they saw was good at listening to them.

We noted that the practice had a rating of two and a half stars on the NHS Choices website (provides a comprehensive health information service) and the practice had taken the opportunity to reply to comments left by patients.

The practice had implemented the family and friends test (FFT), which gives patients the opportunity to provide feedback on services that provide care and treatment to help NHS England improve services.

We spoke with eight patients who attended the practice on the day of our inspection. Comments concerning staff attitude and caring were positive, patients were aware of the services offered at the practice and felt the practice was proactive in making these services known.

The practice had gathered feedback from staff through regular monthly practice and clinical meetings, appraisals and 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 electronically, staff we spoke with were aware of the policy and its purpose.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The GPs and practice nurse were able to maintain their clinical professional learning and development through training and discussion with other professionals. Non-clinical staff had regular appraisals and had undertaken some basic training. We looked at staff files and saw that regular appraisals took place which included a personal development plan.

The practice held monthly practice and clinical meetings to share information and learn from each other. We were told that significant event information was available to staff via the practice intranet. The practice completed regular reviews of significant events and other incidents and were aware of the importance of sharing this information with staff to ensure the practice learnt from events to improve patient outcomes. We found however that not all clinical staff were aware of all significant events which had taken place.

In addition the practice had not made sure that all information relating to vulnerable patients was highlighted to all relevant staff.

Staff also attended monthly 'village' network meetings with other local practices and quarterly CCG area meeting to discuss local area needs and learn from each other.

This section is primarily information for the provider

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person had not protected people against the risk of unsafe or unsuitable use of equipment. This was a breach of regulation 16 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. • People who use the service were not protected against the risks associated with unsafe or unsuitable equipment because of inadequate maintenance. Regulation 15 (1)(e)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risk of abuse. This was a breach of regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. • People who use the service were not protected from abuse through the operation of effective systems and processes. Regulation 17 (2)(b)(c)