

# Cavendish Health Centre

## Quality Report

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Date of inspection visit: 12 November 2015

Date of publication: 03/03/2016

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

## Ratings

Overall rating for this service	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Outstanding	
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 Cavendish Health centre on 12 November 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- 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.
- 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw some areas of outstanding practice including:

- The practice held a Resilience away day which focussed staff on the ability to recover from setbacks, adapt well to change, and keep going in the face of adversity.
- The practice has a Health Advisor for the Elderly (HAFE) who is a highly qualified senior nurse. This is a practice-funded role. Their role is to look after the practice's over 75's. They undertook annual health and social care assessments and home visits as well as advice over the phone. They also liaised with social services and signposted patients to other health, social and voluntary services such as befriending. They provided anticipatory care and helped prevent hospital admissions by keeping patients well at home for longer. Patients are able to contact them directly

# Summary of findings

- The practice had led on a project to improve the use of a clinical records system so that information was entered and coded in a systematic and uniform way that allowed the user to see the key information about patients at a glance. They had created a screen cast which was shared with other local practices who had fed back to the CCG that they had found it very useful.
- Email consultations were provided as the practice was involved in the initial pilot with two other practices. Learning from the pilot has been disseminated to local practices as a report. 199 face to face consultations were saved. This was embedded securely within SystemOne (our GP records) to ensure secure information governance.

**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 good for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement.
- Information about safety was highly valued and was used to promote learning and improvement. A slot for significant events was on the weekly clinical meetings and monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Good



### Are services effective?

The practice is rated good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice had developed clinical protocols so that the links to NICE and other bodies were embedded in clinical practice.
- Data showed that the practice performance was comparable to neighbouring practices in the Clinical Commissioning Group.
- The practice met with other local providers to share best practice.

Good



### Are services caring?

The practice is rated as good for providing caring services.

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

Good



# Summary of findings

## Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

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

Outstanding



## Are services well-led?

The practice is rated as good for being well-led.

- It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. Team away days were held every year and we saw the practice had held a Resilience away day in 2014.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. One GP was a Professional Support Unit coach and Educational supervisor who provided coaching and support to other doctors and the practice manager was supporting a neighbourhood practice to improve their reception and administration functions
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. They had implemented a 'flat management' structure. The practice gathered feedback from patients and it had an active patient participation group (PPG) which influenced practice development. For example we saw that vision strips had been placed on the steps in response to PPG feedback.

Good



# Summary of findings

- The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing slightly below national standards

# 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 outstanding for the care of older people.

- Patients over 75 years had a named GP to co-ordinate their care. The practice was part of the whole systems integrated care (WSIC) project and ran WSIC clinics for over 75s which were attended by GPs, district nurses and social services care coordinators.
- The practice has a Health Advisor for the Elderly (HAFE) who is a highly qualified senior nurse. This is a practice-funded role. Their role is to look after the practices over 75's. They undertook annual health and social care assessments and home visits as well as advice over the phone. They also liaised with social services and signposts patients to other health, social and voluntary services eg befriending. They provided anticipatory care and helped prevent hospital admissions by keeping patients well at home for longer. Patients are able to contact them directly.
- A Primary Care Navigator was based at the practice two days a week, to support older patients and their carers to access timely care and community support. Their role included befriending, attending patients' homes, liaising with social services and acting as advocates.
- The practice participated in the avoiding unplanned admissions Direct Enhanced Service (DES). Data confirmed all unplanned care areas (A&E, Non-elective admissions, Walk in Centre, Urgent Care Centre), had decreased in 2015 compared to 2014.

Outstanding



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- The practice had clinical leads for a variety of long term conditions including diabetes and chronic obstructive pulmonary disease.
- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs.

Good



# Summary of findings

- Patients in these groups had a care plan and would be allocated longer appointment times when needed. They were reviewed every six months and we saw where results were outside the normal range appropriate action was taken.
- Services such as spirometry, smoking cessation and phlebotomy are also provided by the practice. Virtual diabetes clinics were held monthly with the local diabetes nurse.

## **Families, children and young people**

The practice is rated as good for the care of families, children and young people.

- The practice took part in a mother and baby monthly Paediatric Hub Clinic in partnership with other GP practices and consultant paediatricians from the local hospital. We were told the clinic had proved successful in reducing the number of referrals to secondary care and had allowed patients to see a consultant quickly within the community.
- The practice ran a weekly mother and baby and baby immunisation clinics which provided an opportunity for mothers to express any concerns to the GP or nurse that they may have.
- The nurse told us they liaise regularly with health visitor who also attended Multi-Disciplinary Team Meetings.
- The practice offered appointments on the day for all children under 5's when their parent requests the child to be seen for urgent medical matters.
- The GPs demonstrated an understanding of Gillick competency and told us they promote sexual health screening.

Good



## **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 ran evening clinics twice a week which they told us was particularly popular with their working age patients. They offered on-line services which included appointment management, viewing patient records, repeat prescriptions and registration.
- Email consultations were also provided as the practice was involved in the initial pilot with two other practices. Learning from the pilot has been disseminated to local practices as a report. 199 face to face consultations were saved. This was embedded securely within SystmOne (our GP records) to ensure maximum information governance.

Good





# Summary of findings

- They provided Skype consultations twice weekly. The practice set up Skype pilot within the CCG and Learning from pilot was disseminated to local practices via educational meeting and a written report.
- LARC (Long acting reversible contraception) was available on site which reduced the number of medical/nursing appointments that working age women needed to attend regarding contraception.
- The practice also allowed out of area registrations for people who worked in the area.

## People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The GPs told us that patients whose circumstances may make them vulnerable such as the homeless, those under safeguarding or people with learning disabilities were offered regular health checks and follow-up.
- They offered longer appointments for patients with a learning disability.
- The practice care navigator informed vulnerable patients about how to access various support groups and voluntary organisations.
- 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.

Good



## People experiencing poor mental health (including people with dementia)

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- The practice employed a psychologist whose role included supporting patients with mental illness. - These patients had clear treatment plans and we saw data that evidenced of the 17 patient who had completed treatment in October 2015, 14 had improved. The psychologist also provided telephone counselling and supported trainee psychologists on placement at the practice.
- There was also had a primary care liaison nurse for mental health based at the practice half a day a week. Their role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We

Outstanding



# Summary of findings

saw they would refer patients to Improving Access to Psychological Therapies (IAPT), support patients themselves or refer directly to the acute brief assessment team in the local hospital. Where appropriate, longer appointments were offered.

- Patients experiencing poor mental health were invited to attend annual physical health checks and 80% had been reviewed in the past year. They also took part in the shared care Direct Enhanced Services (DES) and had quarterly meetings to discuss these patients and address any concerns.
- There was a dementia lead for and the practice who was also the lead for the CCG. They carried out advanced care planning for patients with dementia and had achieved 100% of the latest QOF points. We saw the practice had carried out an environmental dementia friendly audit and had scored 92% for 'the environment encourages active engagement of people with dementia in their care'. Dementia friendly training had been arranged for all staff at the practice.

# Summary of findings

## What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing below or in line with local and national averages. There were 109 responses and a response rate of 24%.

- 71% found it easy to get through to this surgery by phone compared to a CCG average of 82% and a national average of 73%.
- 79% found the receptionists at this surgery helpful compared to CCG average of 82% and a national average 87%
- 89% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average 82% and a national average 85%
- 73% said the last appointment they got was convenient compared to a CCG average 87% and a national average 92%.
- 55% described their experience of making an appointment as good compared to a CCG average 71% and a national average 73%.
- 62% usually waited 15 minutes or less after their appointment time to be seen (CCG average 57%, national average 65%).

# Cavendish 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 and another CQC inspector.

## Background to Cavendish Health Centre

Cavendish Health Centre provides GP primary care services to approximately 5,500 people living in Westminster. The practice is staffed by three partners and two salaried GPs, one male and four female who work a combination of full and part time hours. The practice is a training practice and employs three trainee GPs. Other staff included three nurses, a health care assistant, a practice manager and seven administrative staff. The practice holds a Personal Medical Services (PMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practices is open from 9.00am to 8.30pm Mondays and Fridays, 8.30am to 8pm on Wednesdays, but were closed for lunch between 12.30pm and 1.30pm. They open 9am to 6.30pm on Tuesdays and 9am to 8.30pm on Thursday, which was particularly useful to patients with work commitments. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded

message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

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

## Why we carried out this inspection

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

## How we carried out this inspection

Before visiting we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 12 November 2015. During our visit we:

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

# Detailed findings

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

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

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

- Older people
- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety.

- They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. Administrative staff and receptionists were encouraged to log any significant event or incident and we saw there was a template located on the shared drive for all staff to complete when an incident occurred.
- Staff we spoke with were aware of their responsibilities to bring them to the attention of the practice manager. These were usually discussed on the day they occurred and at the weekly staff meetings.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw where there was a delay in sending information to a third party due to staff not being clear whether appropriate consent had been given. The practice had reviewed their processes and implemented a new system to ensure that patient consent information was easily accessible in all patient records.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended all external safeguarding meetings.

- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If the practice nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role on occasions. The practice nurse provided chaperone training to the administrative staff members. All staff we spoke with understood their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff providing these duties had been Disclosure and Barring Service checked.
- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. The practice completed a weekly infection control checklist and annual audits were undertaken. and we saw evidence that action was taken to address any improvements identified as a result. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Medicines were stored in medicine refrigerators in the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings, for example the prescribing of

## Are services safe?

antibiotics. The practice regularly liaised with the clinical support unit pharmacist for prescribing advice and support and we saw their prescribing levels were comparable to other local practices.

- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### Monitoring risks to patients

- The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction. This was accessible on all computer desktops for all staff. There was a fire risk assessment in place, all fire had been serviced in August 2015 and a fire drill had taken place in September 2015. There was a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment testing (PAT) had been carried out in

September 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out at the same time.

- The practice manager Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The practice manager occasionally provided cover in reception during busy periods.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was a panic alarm system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and child masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice provided care in line with national guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw the practice had direct computer links to NICE and other local guidelines and clinicians told us they found this much more practical and allowed clinicians to access up to date evidence based care. The practice also developed clinical protocol links to these guidelines and referral pathways. We saw the practice had weekly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions and did not hesitate to ask colleagues for second opinions on occasions.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results, for the period 2014/15, were 91.6% of the total number of points available, with 17% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. The QOF data showed:

- Performance for diabetes related indicators was 88% which was 8.8% above the CCG but 0.8% below national average.
- The percentage of patients with hypertension having regular blood pressure tests was 88.5% which was 4.5% below the CCG average and 9.3% below national average.
- The dementia diagnosis rate was 100%, which was 16.6% above the CCG and 5.5% above the national averages.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes.

- There had been seven clinical audits carried out in the last year. Two were completed where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, one GP had completed a dermatology audit. The aim was to review routine and urgent (2 week wait) dermatology referrals over the course of a year. The practice analysed referral patterns to see whether referrals could be managed within the general practice setting or community dermatology rather than in hospital. The practice carried out a number of actions including in-house training for dermoscopy, raising awareness of community dermatology service and ensured that local pathways completed for certain skin conditions, before considering referrals to other services. After re-audit they found referrals to outpatient dermatology departments had reduced from 58 in 2013 to 45 in 2014.

The team made use of clinical audit tools and clinical meetings to improve performance. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved at their weekly clinical meetings. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice attended a monthly locality meetings run by the CCG. Performance data from the practice was evaluated and compared to similar surgeries in the area.

### Effective staffing

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

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety. The practice also had comprehensive induction packs for each role in the practice which were kept up to date.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support



# Are services effective?

## (for example, treatment is effective)

during sessions, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months

- Staff also completed regular mandatory courses such as annual basic life support and health and safety training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics.
- Staff had access to additional training to ensure they had the knowledge and skills required to carry out their roles and for career development. For example, reception staff told us they had received information governance and customer service training.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and test results.
- All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw they were participating in the Whole Systems Integrated Care (WSIC) pilot and as such worked closely with integrated care teams coordinated by the CCG. GPs told us this had improved communication and sharing of relevant information and had reduced duplication and confusion for patients, carers and staff. All patients had care plans which they had been involved in drafting. They included information about how to manage their conditions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

### Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.
- There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this.
- The practice also documented in patients notes if they had refused a chaperone when offered.

### Health promotion and prevention

Patients who may be in need of extra support were identified by the practice.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. There was an in-house smoking cessation service and patients were signposted to other the relevant service.
- A care coordinator was available at the practice two days a week and smoking cessation advice was available from a local support group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 60%, which was below to the CCG average of 72% and below the national average of 82%. The practice nurse told us they would contact women directly by letter and send text message reminders for patients and would follow up patients who did not attend for cervical screening. However, they said that a high number of women would

## Are services effective? (for example, treatment is effective)

have these test carried out privately and did not always inform the practice. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were better than the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 59% to 83% and five year olds from 46% to 76%. However, flu vaccination rates for the over 65s were 58%, and at risk groups 34% which were below the CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, fever in children and influenza. There was also information about local health and community resources.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The reception desk and waiting area were in separate rooms, which allowed patients to have conversations that could not be overheard from the waiting room.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The two patient CQC comment cards we received were positive about the service experienced. We also spoke with five patients on the day of the inspection and two members of the patient participation group. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were satisfied with the care provided by the practice. However, three of the patients we spoke with were concerned about the time it took to get a routine appointment; they said it could take two to four weeks if they wanted to see a specific doctor.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2015, the practice's internal patient survey and the results from the NHS Friends and Family Test where 83% patients said they would recommend this practice.

Results from the national GP patient survey showed the practice was comparable with the local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 83% said the GP was good at listening to them which was in line with the CCG average of 84% and national average of 89%.

- 77% said the GP gave them enough time which was below the CCG average 81% and national average 87%.
- 96% said they had confidence and trust in the last GP they saw which was above the CCG average 93% and national average 95%.
- 79% said the last GP they spoke to was good at treating them with care and concern which was below the CCG average 83% and national average 85%.
- 74% said the last nurse they spoke to was good at treating them with care and concern which was below the CCG average 86% and national average 90%.
- 79% said they found the receptionists at the practice helpful which was below the CCG average 82% and national average 87%.

### Care planning and involvement in decisions about care and treatment

Patients told us that 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. However, some said that on occasions they did not feel they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average 76% and national average 81%.

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

### Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations,

## Are services caring?

including counselling, cancer support and bereavement services. The practice's website gave listing of all the support available in the GP surgery including carer services and mental health support, which could be accessed through self or GP referral.

The practice's computer system alerted GPs if a patient was also a carer. Patients with caring responsibilities were encouraged to identify themselves to the practice team so that they could be offered additional support if they needed it. The practice had identified 0.3% of the practice list as carers. - Written information was

available to direct carers to the various avenues of support available to them. We also noted the practice had a carer's information event held at the one evening in September 2015.

Staff told us that if families had suffered bereavement, their usual GP contacted them by phone and some would send a sympathy card. 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.



# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

For example the practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised such as A&E attendances, Outpatient audits and prescribing.

Patients over 75 years had a named GP to co-ordinate their care. A Primary Care Navigator was based at the practice two days a week, to support older patients and their carers to access timely care and community support. Their role included befriending, liaising with social services and acting as advocates. The practice also employed their own Health Advisor for the Elderly (HAFE) whose role was to provide information about generic health issues associated with ageing. This nurse specifically focused on older people care and carried out home visits. The practice participated in the avoiding unplanned admissions DES. We saw data that confirmed all unplanned care areas (A&E, Non-elective admissions, Walk in Centre, Urgent Care Centre), had decreased overall by 200 attendances in 2015 compared to 2014.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed. Reception staff supported clinicians in ensuring annual reviews were completed for all patients in this group. They had a system in place that sent out review letter appointments triggered by the patient's birthdays.

The nurse had been trained to start insulin injections and we saw virtual diabetes clinics were held monthly with the local diabetes nurse where patients whose HbA1C blood count was high would be reviewed.

The practice ran monthly mother and baby Paediatric Hub Clinic in partnership with consultant paediatricians from the local hospital, which was rotated between three local practices. We were told us the clinic had proved successful in reducing the number of referrals to secondary care and had allowed patients to see a consultant quickly within the community. A health visitor was based at the practice and they ran weekly mother and baby clinics which were supported by a GP. They told us they found this helpful as it allowed them to discuss any concerns they had immediately with the GP. The practice offered appointments on the day for all children under 5 when their parent requested the child be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening.

LARC (Long acting reversible contraception) was available on site which reduced the number of medical/nursing appointments that working age women need to attend regarding contraception.

The GPs told us that patients whose circumstances may make them vulnerable such as people with learning disabilities were coded on appropriate registers. Learning Disability patients were given care plans that met their needs. They worked within a multi-disciplinary team that met monthly to plan the care and management of vulnerable patients.

The practice offered working age patients access to extended appointments twice a week. They offered on-line services which included appointment management, viewing patient records, repeat prescriptions and registration. Email consultations were also provided as the practice was involved in the initial pilot with two other practices. Learning from the pilot has been disseminated to local practices as a report. 199 face to face consultations were saved. This was embedded securely within SystmOne (our GP records) to ensure secure information governance.

They also provided Skype consultations twice weekly where approximately 12 consultations per week took place. We saw consent was recorded on patient notes. The practice set up Skype pilot within the CCG and Learning from pilot was disseminated to local practices via educational meeting and a written report. The practice also allowed out of area registrations which meant that people who worked in the area but lived elsewhere could also register with the practice.



# Are services responsive to people's needs?

(for example, to feedback?)

The practice employed a psychologist whose role included supporting patients with mental illness. These patients had clear treatment plans and we saw data that evidenced of the 17 patient who had completed treatment in October 2015, 14 had improved. The psychologist also provided telephone counselling and supported trainee psychologists on placement at the practice.

The practice had access to a primary care liaison nurse for mental health based at the practice one day bi-weekly. Their role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We saw they would refer patients to Improving Access to Psychological Therapies (IAPT) or support patients themselves.

The practice had a register of patients experiencing poor mental health. These patients were invited to attend annual physical health checks and 80% had been reviewed in the past year. They had quarterly meetings with community psychiatric teams to discuss these patients and address any concerns.

There was a dementia lead for and the practice who was also the lead for the CCG. They carried out advanced care planning for patients with dementia and had achieved 100% of the latest QOF points. We saw the practice had carried out an environmental dementia friendly audit and had scored 92% for 'the environment encourages active engagement of people with dementia in their care'. Dementia friendly training had been arranged for all staff at the practice.

The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. Accessible toilet facilities were available for all patients attending the practice. They had access to interpreters when needed.

## Access to the service

The practice was open from 9.00am to 8.30pm Mondays and Fridays, 8.30am to 8pm on Wednesdays, but was closed for lunch between 12.30pm and 1.30pm. They open 9am to 6.30pm on Tuesdays and 9am to 8.30pm on Thursday, which was particularly useful to patients with work commitments. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours. Longer

appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Pre-bookable appointments could be booked up to two weeks in advance; urgent appointments were available for people that needed them.

The practice also offered email consultation and we saw data that demonstrated that 199 face to face and telephone appointments were saved and were therefore available for patients who needed to visit the practice.

They also had a GP who provided both telephone consultations and a triage service. The practice said this provided expert care at the point of contact. This had reduced the need for patients to have an appointment with a GP.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 62% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 71% patients said they could get through easily to the surgery by phone compared to the CCG average of 82% and national average 73%.
- 55% patients described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 62% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 56% and national average of 65%.

## 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. All verbal complaints were recorded on a spreadsheet.
- The practice managers handled all complaints in the practice. We saw that these were analysed on a quarterly basis and the outcome and actions were sent to all members of staff. We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given



## Are services responsive to people's needs? (for example, to feedback?)

to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last 12 months and found these were dealt with in a timely way, in line with the complaints policy and there were no themes

emerging. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we saw that where patients had complained about repeat prescriptions not being given for various reasons, the practice had written and apologised to the patient and had reviewed their prescription request process.



# 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 had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice vision and values was investing in staff through structured coaching, leadership and training. All staff we spoke with knew and understood the vision and values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were monitored at their annual away day.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.
- The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff had to read the key policies such as safeguarding, health and safety and infection control as part of their induction. All seven policies and procedures we looked at had been reviewed annually and were up to date.
- The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing slightly below national standards. They had scored 825 out of 900 in 2014 and 512 out of 559 in 2015 which was 4.9% above the CCG average and 1.9% below England average. We discussed this with the partners who told us that during the period that the Qof covered three out of the four partners were absent from the practice due to unforeseeable circumstances. This meant there was only one partner in the practice and a number of locums and trainees. They said they employed known locums to minimise disruption to patients where possible. This

also coincided with changes to their clinical systems and the data transfer and read codes in particular did not run smoothly. We saw the practice now have contingency measures in place to avoid this situation happening again. In addition, during this time, they adequately covered clinics and related work and kept the patients updated by displaying a letter in the practice and their website.

- We saw QOF data was regularly reviewed and discussed at the weekly clinical and monthly practice meetings.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements. There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records.

### Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty and there were systems in place to ensure all staff were made aware of notifiable safety incidents.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence

There was a clear leadership structure in place and staff felt supported by management.



# Are services well-led?

Good 

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

- Staff told us that the practice held regular team meetings. We saw from minutes that 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. They felt they worked well together and that they were a highly functional team which listened and learnt, and were aware of their areas for improvement, such as the need to improve their cervical screening.
- We noted that team away days were held every year and we saw the practice had held a Resilience away day in 2014, which focussed on the ability to recover from setbacks, adapt well to change, and keep going in the face of adversity.
- Staff said they felt respected, valued and supported, particularly by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages. For example 55% patients described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%. The practice told us they were in the process of reviewing their telephone systems and would also be increasing GP sessions.
- There are high levels of staff satisfaction. The practice had gathered feedback from staff through a culture and leadership staff survey and we saw staff had rated the practice highly in all areas. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement such as staff away days and generally through staff meetings and appraisals. Staff at all levels were actively encouraged to raise concerns. All staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged to improve how the practice was run.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, last year's survey had identified concerns about some members of the reception team's approach to patients. As a result all receptionists attended an 'Empathy and Compassionate Care' course in January and February 2015 and all receptionists attended 'Patient Experience' training in March, April and May 2015. Further, some of the reception team attended 'Dementia Awareness' and 'Mental Health Awareness' training in May 2015. Other staff told us this knowledge was then cascaded to other team members.

## Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice nurse was part of the Primary Care Mentorship Pilot. They had completed mentor training through the Primary Care Mentorship Pilot run by University of West London, College of Nursing, Midwifery and Healthcare. The mentorship was part of a drive to educate secondary care nurses so they could move into primary care. One nurse who had been part of the mentorship scheme had been employed by the practice. Another, nurse was on the Board at Central London Healthcare (CLH) GP Federation.

They were also a training practice for GPs and at the time of our inspection they employed two trainee GPs

One of the GPs is on the CCG Governing Body and another one was the educational lead for Central London CCG. We saw they had led on a project to improve the use of SystemOne so that information was entered and coded in a systematic and uniform way that allowed the user to see

# Are services well-led?

Good 

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

the key information about patients at a glance. They had created a screen cast which was shared with other local practices who had fed back to the CCG that they had found it very useful.

We found there was a strong culture of support and staff development at the practice members of staff had been supported to complete leadership courses such as BTEC level 2 Diploma in team leading.

A systematic approach was taken in working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. All partners were involved in various external boards and organisations

such as CCG and CLH boards and one GP was the curriculum managing editor of a RCGP publication. We saw that information from all these forums were fed back to practice staff at monthly practice meetings

One GP was also a Professional Support Unit coach and Educational supervisor in supporting other GPs and the practice manager was supporting a neighbourhood practice.

The practice also had an apprenticeship scheme for administrative staff and had employed two trainees to date, one of whom had gone on to become permanent worker at the practice.