Richford Gate Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Richford Gate Medical Centre provides primary medical services to approximately 10,200 patients in the Goldhawk Road area of West London. This is the only location operated by this provider.

We visited the practice on 1 and 2 October 2014 and carried out a comprehensive inspection of the services provided.

We rated the practice as ‘‘Good’ overall; ‘Good’ in four domains in asking if the service is caring, effective, responsive and well-led; and ‘Good’ for the care provided to five of the six population groups we looked at including: older people; people with long-term conditions; working age people (including those recently retired and students); people living in vulnerable circumstances; and people experiencing poor mental health (including people with dementia). We rated the practice as ‘Requiring Improvement’ under the safe domain and for the population group families, children and young people.

Our key findings were as follows:

The practice provided an effective, caring, responsive and well led service. Patients’ needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. We saw from our own observations and heard from patients they were treated with dignity and respect. The practice understood the needs of its patients and was responsive to them. The practice was well-led, had a clear ethos that put patients first and was committed to providing the best possible service to them. There was an open culture and staff felt supported in their roles.

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

The provider should:

- Ensure all staff receive up to date training in child protection and safeguarding of vulnerable adults;
- Arrange infection control refresher training for all staff, in line with the practice’s infection control policy;
- Undertake more effective monitoring and review of the outcome of clinical audits to ensure the completion of the full audit cycle; and

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- Hold more regular formal, minuted administrative staff meetings, to help in keeping track of agreed actions and in reviewing progress at subsequent meetings.

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 safe, as there are areas where improvements are required or should be made. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and actioned. Risks to patients were assessed and well managed. There were enough staff to ensure people received safe care. Not all staff had up to date training in infection control in accordance with the practice's infection control policy. In addition, not all staff had received up to date training in child protection and safeguarding of vulnerable adults.

Are services effective?

Good

The practice is rated as good for effective. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. There were appropriate arrangements in place to monitor review, and improve performance. The practice participated in clinical audit and routinely collected information about patient care and outcomes. However, the practice's monitoring and review of the outcome of clinical audits was not as effective as it could be in ensuring the completion of the full audit cycle. There were arrangements in place to support staff appraisal, learning and professional development. Appraisals for non-clinical staff were on hold in the current year to focus on the introduction and training for a new clinical computer system, and would be re-instated in 2015/16. However, staff learning and development needs had been discussed and agreed and staff had continued to undertake relevant training. The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment. The practice promoted good health and prevention and provided patients with suitable advice and guidance. The practice offered a full range of immunisations for children.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect. We observed this during the

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inspection and saw that confidentiality was maintained. Patients were involved in decisions about their care. Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice understood the needs of its patients and was responsive to these. The practice had recognised the needs of different groups in the planning of its services. The practice had participated in a number of local enhanced services (LES) and direct enhanced services (DES) schemes to improve the management and delivery of care to specific patient groups. Data showed the practice was rated 'among the best' for accessibility of appointments. In response to patient feedback the practice were allocating a named GP to each patient and had introduced initiatives to improve access to appointments, including additional clinics and extended opening hours. The practice learned from patient experiences, concerns and complaints to improve the quality of care. There was an accessible complaints system with evidence of shared learning from complaints with staff and other stakeholders. The premises and services had been adapted to meet the needs of people with disabilities.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear ethos which involved putting patients first and staff were committed to providing them with the best possible service. Staff understood the practice mission statement, were committed to its aims and were clear about their responsibilities in relation to this. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice held monthly clinical governance meetings. The practice took part in local peer review with neighbouring GP practices as part of the CCG's network arrangements. The practice had appropriate risk management processes in place. The practice had a number of policies and procedures in place to govern activity and these were regularly reviewed and were up to date. The practice also had a quality manual under its accreditation for ISO 9001, an internationally recognised standard for the quality management of businesses, covering mainly administrative procedures. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received induction training, regular performance reviews and attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. There were effective arrangements in place to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. The practice were allocating named GPs for each patient. The practice engaged in an enhanced service scheme to introduce care plans for older people. Home visits were carried out by the GP for older patients who were not well enough to attend the surgery. The practice worked closely with district nurses to support the care and treatment of housebound patients. There were also arrangements in place for engagement with other health and social care providers. The practice referred patients with complex needs to a local clinical commissioning group (CCG) network based 'Virtual Ward' and a multidisciplinary older people's rapid access (OPRAC) service for assessment and treatment. There were appropriate and effective end of life care arrangements in place. The practice was Gold Standards Framework (GSF) accredited.

People with long term conditions

Good

The practice is rated good for the population group of people with long term conditions. There were safe arrangements in place to review medication for patients with long term conditions, including regular monitoring in line with national guidance. The practice provided GP led diabetic clinics and the practice nurse ran chronic obstructive pulmonary disease (COPD) and asthma clinics. Care plans had been introduced to care for people with long-term conditions which included setting patient goals and the provision of extended appointments. Practice meeting minutes reported working with community services such as hospitals, social workers, midwives, district and palliative care nurses to deliver a multidisciplinary package of care. The practice participated in local CCG network reviews of long term conditions in speciality areas such as cardiology, dermatology, urology and ear, nose and throat (ENT).

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the population group of families, children and young people. The practice ran a joint clinic with health visitors for six-eight week baby checks and provided a fast access service for babies to see a GP. Sexual health was promoted by hosting the West London sexual health clinic. The clinic offered a range of services including contraception, smears and testing for sexually transmitted diseases (STD). The practice had

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links to a local domestic violence support unit and one of the partner GPs was the designated practice domestic violence champion. There were appropriate arrangements in place to safeguard children and young people. However, not all staff had received up to date training in child protection. The practice was developing a policy on Female Genital Mutilation (FGM) and one of the GP partners was leading on this working with local groups. The practice offered a full range of immunisations for children and the Human Papilloma Virus (HPV) vaccination was offered to young girls. Immunisation rates for the standard childhood immunisations was mixed. According to NHS England data for 2013/14, the percentage receiving a vaccination at the practice was below the average within the CCG area for the majority of vaccinations in the 12 and 24 months age group; and above the average within the CCG area for the majority of vaccinations in the five years age group.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). 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 practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. The practice offered all patients in the 45-74 age group a health check and at the time of the inspection had the best record in the CCG for the number of these health checks completed for patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice carried out regular monitoring of patients living at two local learning disability centres. A review of A&E attendance had identified frequent attendees from the centres. As a result, the practice had put in place frequent reviews of these patients working with other services to help and support the patients, their care workers and families. All patients with a learning disability were offered a physical health check annually. There were no additional services for homeless people but the practice offered the same service to these people as other patients. The practice had access to interpreter and translation services and the website had a translation facility in a wide range of languages. The practice made fortnightly home visits to patients in local 'extra care' accommodation with many of these patients having complex needs and suffering from dementia. Staff

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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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health (including people with dementia).A member of staff from the Community Mental Health Team was based at the practice offering child psychology services to registered patients and the wider community. A primary care mental health worker held a clinic one afternoon a week to provide support for discharged patients and facilitate referrals. There were close links with a local personality disorder consultant for e-mail support and advice and there was daily use of a telephone psychiatry hot-line to a consultant for psychiatric advice. In addition, the practice facilitated patients' access to the local 'Improving Access to Psychological Therapies (IAPT) programme'. The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND. The practice monitored repeat prescribing for people receiving medication for mental health needs. Where patients lacked capacity, the practice took account of the Mental Capacity Act 2005 and involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment.

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What people who use the service say

We received 39 completed Care Quality Commission (CQC) comments cards providing feedback about the service. We also spoke with seven patients and two representatives of the practice's patient participation group (PPG) on the day of our inspection. The majority of patients were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were welcoming, efficient, helpful and caring. Staff treated them with dignity and respect, listened to them and met their needs. All consultations and treatments were carried out in the privacy of a consulting room. Patients felt the practice was safe, clean and hygienic. A minority of patients were less positive and expressed dissatisfaction mainly with difficulties in booking an appointment and getting through to the surgery on the telephone during busy times.

Members of the PPG we spoke with said any concerns the group had raised with the practice had been responded to appropriately. We looked at the patient survey of 205 patients conducted through the group for 2013/2014 and saw that key themes related to access to appointments and waiting times. We noted from the group's 2013/14 action plan a number of steps taken to address these issues, including longer reception opening times, a new text messaging service which enabled patients to cancel appointments by text and 'catch-up' slots within each GP surgery to help reduce over-running.

In the 2013/14 national patient survey, 89 percent of respondents would recommend the surgery to someone new to the area, which was among the best ratings nationally. Other areas where the practice was rated highly included patients who said the last GP they saw or spoke to was good at treating them with care and concern (90 percent) and those who described their experience of making an appointment as good (79 percent). Areas in which the survey indicated the practice could improve included waiting times when patients attended for appointment, being able to see a preferred GP, and getting an appointment. We saw this and other patient feedback data was passed to the practice's patient participation group (PPG) for review and action planning to improve performance in these areas.

Areas for improvement

Action the service SHOULD take to improve

- The majority of staff had received training in child protection and safeguarding of vulnerable adults and staff had a good understanding of the signs of abuse and how to report any concerns. However, one member of the clinical staff did not have up to date training in child protection and two members of staff (one GP and one administrator) had not done update training in safeguarding of vulnerable adults. This training was included in the practice's training plan for 2014/15 and should be arranged as soon as possible.
- Infection control refresher training should be arranged for all relevant staff, in line with the practice's infection control policy.
- The practice participated in clinical audit and routinely collected information about patient care and outcomes. However, the practice should undertake more effective monitoring and review of the outcome of clinical audits to ensure the completion of the full audit cycle.
- Meetings for administrative staff were held on an ad hoc basis to brief staff on important developments and were not minuted. The practice should hold more regular meetings with a formal record which would help in keeping track of agreed actions and in reviewing progress at subsequent meetings.

Richford Gate Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Why we carried out this inspection

Background to Richford Gate Medical Centre

How we carried out this inspection

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice had appropriate procedures in place to report and review incidents, complaints and safeguarding concerns and ensure safe patient care was maintained. The number of incidents was low but where they had occurred investigations, outcomes and actions were clearly documented. All patients we spoke with during the inspection told us they felt safe in the care of the doctor and nurses at the practice.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). There was a nominated lead GP responsible for reviewing and distributing any alerts and guidelines to medical staff within the practice. We saw an example of a recent email distributed regarding the findings and recommendations of a Hormone Replacement Therapy (HRT) study.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff including receptionists, administrators and nursing staff were aware of the process to follow and we saw the form used to report significant events to the practice's clinical meetings. The practice kept records of significant events and these were made available to us for events that had occurred during the last 12 months. Significant Events were reviewed as a permanent item on the practice's monthly clinical meeting agenda. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. In one case the importance was highlighted of considering lung cancer in those with chronic obstructive pulmonary disease (COPD) if they were not responding to usual treatment and the need to initiate a review of the treatment with hospital specialist respiratory teams. In addition, procedural changes were agreed to ensure the timely provision of patient information to the practice and the GPs at the practice were encouraged to discuss any concerns via a respiratory telephone hotline or via email.

Reliable safety systems and processes including safeguarding

The practice had appropriate safeguarding policies in place for both children and vulnerable adults, including contact details for local safeguarding agencies. The contact details were on display and easily accessible throughout the practice. The practice had a nominated GP lead for safeguarding of children and a GP lead for safeguarding of vulnerable adults was due to be nominated shortly. All staff we spoke with knew who the child protection lead was, how to recognise signs of abuse and the process to follow if they suspected abuse. A log containing staff training records for medical, nursing and administrative staff was made available to us before the inspection. We also examined staff records during the inspection which included certificates of training completed. The training records indicated that all but one of the clinical staff had completed up to date child protection training. All administrative staff were trained at level 1, nursing staff level 2 and GPs at level 3 in accordance with national guidance. Refresher training had been booked for the one member of staff, a health care assistant who did not treat children as part of their role. However, they had an acceptable understanding of signs of abuse and the process to follow if they suspected abuse.

The majority of staff had completed up to date training in safeguarding of vulnerable adults. One of the GP partners and one of the reception team had not completed this training but were included in the practice training plan to ensure they completed it within the current financial year. They both nevertheless had a good understanding of the signs of abuse and how to report any concerns. The practice had produced an 'easy read format' patient information booklet on safeguarding adults which was available in the waiting room for patients. A copy of the booklet had also been given to all staff.

Although a chaperone policy was in place, the notice to inform patients of this was not displayed in the waiting room or consulting rooms until pointed out by the inspection team. The chaperone policy contained guidelines to help decide if a chaperone was needed, who can act as, and the role of a chaperone, and confidentiality requirements. The policy recommended that chaperones should be clinical staff but if nursing staff were not available to act as a chaperone, some of the receptionists occasionally undertook this role. Staff we spoke with understood their responsibilities when acting as chaperones and had received appropriate instruction in the role. Clinicians recorded in the patient's notes that a

chaperone had been offered and either accepted (with the initials of the chaperone) or declined by the patient. The chaperone made an entry in the patient's record after the examination. All medical staff and staff acting as chaperones present during intimate or personal examinations had undergone a criminal records check.

The practice had specific codes on their clinical system for identifying patients subject to safeguarding concerns. Notes on family members were added where appropriate. The doctors attended safeguarding conferences where necessary. Safeguarding was a standing item on the agenda for monthly clinical meetings and the safeguarding lead provided feedback to the practice team on issues arising from safeguarding meetings.

Medicines Management

The practice had up-to-date medicines management policies in place. There was a kit containing emergency medicines. Appropriate arrangements were in place to ensure immunisations and travel vaccines were stored at the correct temperature within a designated medicine fridge. The practice nurse showed us evidence that the fridge temperature had been checked on a daily basis to ensure it remained within acceptable limits and that the vaccines were safe to use. The practice nurse maintained medicine stock records and monitored medicine expiry dates.

Records showed one practice nurse was qualified as a nurse prescriber. In addition there were patient group directives (PGDs) in place in line with relevant legislation. The other member of the nursing team who was not a qualified subscriber had signed all the necessary PGDs and the folder containing these was up to date.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. Repeat prescriptions could be ordered online or in person at the practice. Patients were asked to allow two full working days for repeat prescriptions to be processed. Patients we spoke with who used the repeat prescription service said it worked well.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice said regular reviews and medication management plans were in place for those patients. We saw protocols for the medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis.

We were told patient records were flagged to identify when they were due for a medicine review and arrangements were made for them to attend the surgery or receive a home visit for this if they were housebound. Patients we spoke with who received repeat prescriptions confirmed that their medication was regularly reviewed, including during home visits.

Cleanliness & Infection Control

The practice had an infection control policy. A practice nurse was the named infection control lead. The policy stated that training on infection control should take place annually for all staff but only one of the nursing team had undertaken up to date infection control training. However, the infection control lead attended an infection control course shortly after the inspection and we were told they would be providing refresher training for the rest of the practice team. Staff were provided with personal protective equipment including gloves, masks, disposable aprons, and protective goggles. There were occupational health arrangements in place to ensure that all staff who obtained or handled pathological specimens were protected against Hepatitis B. We saw the immunisation status of relevant staff was up to date. The practice was following up the status of one GP whose record was not available during the inspection.

We noted the practice was subject to an annual infection control audit by the owners of the building, NHS Property Services. The audit covered the whole building which the practice shared with the Central London Community Healthcare NHS Trust (CLCH). The practice manager confirmed that action arising for the practice from the June 2013 audit had been implemented. The 2014 audit had taken place recently and whilst the report was awaited, we were told by the practice manager the preliminary feedback indicated there were no concerns for the practice.

On the day of the inspection visit hand cleansing gel, soap and paper towels were available for use throughout the practice. Hand hygiene posters were also on display.

CLCH took the lead for maintaining the cleaning of the premises under a contract managed by NHS Property Services. No cleaning staff were directly employed by the

practice. However, the reception manager was the practice co-ordinator for the cleaning service and reported any issues to CLCH. We saw that there were cleaning schedules posted in each room which were completed for each cleaning visit. We observed the premises to be clean and tidy on the day of the inspection.

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

An up to date Legionella risk assessment was in place and there was regular testing of the water systems and temperatures. The practice had arrangements in place with the building landlords for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed that regular checks were carried out in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

There were appropriate arrangements in place for the management of the practice building and facilities provided by NHS Property Services and an appointed maintenance contractor. We reviewed the relevant management folder and saw up to date records of fault logging and repairs and emergency escalation procedures for reactive maintenance, which formed part of a planned preventative maintenance schedule.

We saw the up to date records of monthly checks which included emergency lighting, water temperature, and safety checks on doors. There were weekly checks of the fire alarm and fire fighting equipment and an annual inspection of portable fire extinguishers was carried out in September 2013. There were records that portable appliance testing (PAT) had been carried out in April 2014. The gas boiler had undergone a maintenance and safety check in March 2014. Other medical equipment tests and calibration checks to ensure they remained suitable for use were completed annually. We saw the records for the checks completed in December 2013 which included blood pressure monitors, weighing scales, spirometers, nebulisers, the vaccine fridge, ultrasound equipment and thermometers.

Staffing & Recruitment

The practice had a recruitment policy and procedure which included a documented selection interview process and appropriate pre-employment checks to ensure that patients were cared for and supported by suitably qualified, skilled and experienced staff. All staff also received a comprehensive induction as part of part of the recruitment process.

We found many of the staff had been employed before the practice was registered with the Care Quality Commission and there had been limited recent recruitment activity as staff turnover was low. However, we spoke with the most recently recruited member of staff who told us they completed an application form when they applied for the post and attended a selection interview. They said they had been asked to provide references, confirmation of professional registration, proof of address and identity and had completed a criminal records check. They confirmed they had been provided with a clear job description and received a thorough induction. We saw evidence on their staff record of these processes and a comprehensive induction checklist which they were undergoing at the time of the inspection.

The practice had a Disclosure and Barring (DBS) policy for criminal record checks which set out the criteria and level for such checks. All but staff unlikely to come into contact with patients were required to undergo a check and the practice manager confirmed all clinical, reception and administrative staff had been checked. Professional registration was checked and up to date for clinical staff.

We were told the practice's use of locum doctors had reduced significantly by the appointment of a salaried GP and the appointment of another was under consideration. Where they were used, the practice received details from the locum agency to confirm all appropriate checks had been carried out to ensure their competence and suitability for the locum role. No locums were employed at the time of the inspection.

Monitoring Safety & Responding to Risk

The practice had risk management processes in place including a health and safety procedure and a policy for managing the environment. These formed part of the quality manual under the practice's accreditation with ISO 9001, an internationally recognised standard for the quality management of businesses. The practice carried out regular health and safety audits. We saw the audit

completed in April 2014 and noted the action plan from it had been implemented. The practice manager told us that in addition to formal audits staff carried out continuous informal checks on the premises on a day to day basis.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, we saw an audit had been completed by the practice in the last year for patients who had an anti-coagulant as a repeat prescription. The treatment of 83 percent of patients met the audit standards and follow up action had been taken for those that did not, including notifying the CCG Prescribing Adviser of the action taken.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, one patient with long term conditions told us the practice rang them at home to check how they were after a blood test. They were not feeling well and staff reacted straight away, phoned for an ambulance and ensured they were taken care of.

The practice was drawing up a policy on Female Genital Mutilation (FGM) and one of the GP partners was leading on this working with local groups.

The practice carried out regular monitoring of patients living at two local learning disability centres. A review of A&E attendance had identified frequent attendees from the centres. In response, the practice had put in place frequent reviews of these patients, working with other services to help and support the patients, their care workers and families.

A member of staff from the Community Mental Health Team was based at the practice and offered child psychology services to patients registered at the practice and the wider community.

The practice monitored repeat prescribing for people receiving medication for mental health needs. They made daily use of a telephone psychiatry hot-line to access a consultant psychiatrist for advice. The practice sign-posted patients experiencing poor mental health to various support groups and third sector organisations including MIND.

Arrangements to deal with emergencies and major incidents

The practice had emergency equipment available including a defibrillator, pulse oximeter and oxygen cylinder. Staff completed weekly checks of oxygen levels and defibrillator and pulse oximeter operation and we saw the records for this. Staff had received up to date training in dealing with medical emergencies.

The practice business continuity plan set out the arrangements to be followed in the event of major disruption to the practice's services. To help maintain services the practice had an agreement in place with a nearby practice it networked with as part of the CCG's network arrangements. This enabled them to share the other practice's computer system and reception services in order to maintain services in the event of a major disruption.

There were monthly fire alarm tests and a designated evacuation assembly point if the building had to be vacated. We looked at the fire drill and evacuation plan and noted the records of regular drills that had been carried out. Staff received training in fire safety.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Best practice standards and guidelines were followed in the assessment and planning of patients' healthcare needs. The GPs kept up to date with relevant professional guidance through continuing professional development. In addition to the process in place for disseminating within the practice guidelines from the National Institute for Health and Care Excellence (NICE), GPs used a 'clinician's toolkit' to access relevant clinical guidance. Practice nursing staff attended regular Royal College of Nursing study days to update their skills and knowledge. Care planning and management of individual patients and groups of patients with specific conditions was reviewed at monthly clinical meetings. All clinical staff attended these if they were available, including nursing staff. Meeting minutes showed that discussions included a review of patients on the palliative care register, the establishment of a care planning register and the identification and notification of patients placed on the register, new cancer diagnoses and the process of referral of patients to the community mental health team.

We saw no evidence of discrimination when making care and treatment decisions.

There were arrangements in place to obtain and record a patient's consent, including obtaining consent when treating children. Where patients lacked capacity the practice took account of the Mental Capacity Act 2005 and involved social services, family members, and carers to enable appropriate choices and decisions about their care and treatment. Clinical staff understood the Gillick guidelines for gaining consent from children under age 16.

Management, monitoring and improving outcomes for people

The practice routinely gathered information about peoples' care and outcomes. It used the Quality and Outcomes Framework (QOF) to assess performance and carried out regular clinical audit. The QOF is a national group of indicators, against which a practice scores points according to their level of achievement in the four domains of clinical, organisation, patient experience and additional services. QOF data showed the practice performed in line with other practices in the local CCG in the majority of indicators. It performed particularly well on some indicators, for example, in producing registers of patients aged 18 and over with learning disabilities; of all patients in need of palliative care/support irrespective of age; and in holding regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.

We noted that the practice performance in the QOF reports for 2013-2014 showed a total of 92 percent of QOF points achieved in the clinical domain which was above the CCG average. We noted that for the majority of indicators the practice achieved above the CCG average and for three indicators below the CCG average. Within the domains of organisation, patient experience and additional services the majority of practice scores were above or equal to the CCG and national averages.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits undertaken in the last 12 months included audits of cervical screening smears, International Normalisation Ratio (INR) monitoring for patients who had anticoagulants as a repeat prescription, unscheduled A&E admissions and vitamin D supplementation. Some of these audits were undertaken as part of the GPs' appraisal or revalidation process.

Clinical audits demonstrated action planning for the improvement of the practice or patient care. We saw from monthly clinical meeting minutes that the results of audits were shared with the clinical team and follow up action agreed. For example, the INR audit found positive results for the majority of patients. In the minority of cases where audit standards were not met it was found a local domiciliary service was not communicating INR results to the practice. The CCG prescribing adviser was provided with feedback about the issue and the service was asked to provide the most recent INR, and future results, of all patients concerned. Whilst it was clear that the practice undertook regular clinical audits, It was not readily evident from clinical meeting minutes that changes resulting since the initial audit had been monitored and reviewed further to test their effectiveness and complete the full clinical audit cycle. However, during the inspection the practice implemented a formal tracking system to enable progress on the implementation of audit action plans and other improvement actions agreed at the meetings to be more effectively monitored and reviewed.

Good

Are services effective?

(for example, treatment is effective)

We noted the practice had participated in a national direct enhanced service (DES) scheme over the past two years to introduce care plans for older people. Shortly before the inspection they had achieved all of the requirements of the scheme.

Effective staffing

We saw evidence that the GPs kept their skills up to date through regular training and continuing professional development. The GPs we spoke with said they had undertaken an appraisal and were up to date with or were soon due for their revalidation.

There was an appraisal system for nursing and non-clinical staff which included a review of performance, objective setting and the identification of learning and development needs. We saw on staff records evidence of completed appraisal reports. However, the practice had taken the decision not to carry out formal appraisals of nursing and non-clinical staff in the 2014/15 reporting year because of priority given to the implementation of and staff training in a new clinical computer system. Staff confirmed, however, that there had still been opportunities throughout the year to discuss and agree with their managers learning and development needs and they had continued to undertake relevant training.

Staff did not receive formal supervision but said they could access a manager for advice whenever they needed to. Nursing staff attended the practice's clinical meetings when they were available. The managers of the reception and administrative teams arranged ad hoc meetings for non-clinical staff if important information or developments needed to be cascaded. The practice also arranged an annual away day to foster team building and discuss future practice development.

There was staff handbook containing appropriate human resource policies which were last reviewed in October 2013. The practice also had a quality manual under its accreditation for ISO 9001 covering mainly administrative procedures including health and safety, document control, key receptionist procedures, complaints, quality policy review, access to health records and confidentiality and incident handling and reporting. Separate clinical practice policies and procedures were also accessible to all staff.

We looked at the records of 16 individual staff which showed that they had received mandatory training and any additional learning and development identified as part of the appraisal system. We were also shown the training matrix for each job role.

All the staff we spoke with said they felt equipped to do their job and were supported in their role.

Working with colleagues and other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach to meet patients' needs and manage complex cases.

Clinical meeting minutes recorded multidisciplinary working with hospitals and community services such as social workers, midwives, district and palliative care nurses and the community mental health team. District nurses, members of the palliative care team and a mental health worker attended clinical meetings quarterly. There were also close links with contraception and sexual health services, a sickle cell service (sickle cell is a disease that affects the blood) and a complementary health clinic based at the site. The practice made referrals to these services where appropriate.

Patients with complex needs at risk of admission to hospital were referred to a local CCG network based 'Virtual Ward' bringing together acute, community and social care professionals to work as one team. The Virtual Ward enabled this multi professional team of clinicians to care for patients in their own home. The practice also referred patients to a multidisciplinary older people's rapid access (OPRAC) service for assessment and treatment. In addition the practice facilitated patients' access to the local 'Improving Access to Psychological Therapies (IAPT) programme which provided self-help courses for patients with common mental health difficulties such as stress, worry and low esteem.

There was an effective system in place for arranging and reporting the results of blood tests, x-rays and smear tests for example. This included a timely follow-up system to ensure these had been seen by the GP and actioned. If test results were normal, reception staff provided the results to patients when they called in. If the test was abnormal when they reviewed the result the GPs sent a letter out to the

Good

Are services effective?

(for example, treatment is effective)

patient inviting them to attend for an appointment to discuss the results. Patients we spoke with were complimentary about the speed of the results service and the clarity of explanations about the results.

The practice had an out of hour's (OOH) arrangement in place with an external provider and patients were advised that they could also call the 111 service for healthcare advice. All letters following OOH services provided were submitted electronically to the practice and reviewed by the duty GP for same day action where needed.

Patients were given a choice about referrals for hospital appointments but the 'Choose and Book' service was only currently used by two of the doctors. We were told that the previous clinical computer system prevented ready access to the service. However, this was not the case under the new system introduced recently and the practice would be making wider use of the service in future. Referral letters were dictated by the GP in the presence of the patient which helped ensure a quicker turnaround of referral letters for despatch. We saw evidence that the one of the GPs had carried out a first cycle audit of their referral practice and had identified scope for improvement in referral letters. The second cycle audit to review the improvements had yet to be completed.

The practice had an effective process in place to follow up patients discharged from hospital. Discharge summaries were received electronically in most instances and were followed up by a GP within 48 hours. The practice participated in a local enhanced service (LES) reviewing discharged patients to determine if a hospital admission had been necessary. One patient we spoke with told us how, on discharge from hospital, the surgery picked up on and managed their changed needs immediately and arranged follow up appointments and care.

For end of life care the practice had arranged for 'Just in Case' medicines boxes to be placed in patients' homes to support them when they experienced new or worsening symptoms outside of normal GP practice hours. This helped to avoid distress caused by poor access to medicines in the out of hour's period, by anticipating symptom control needs.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. This had been introduced into the practice during the year and staff were now fully trained on the system. We were told that this year's administrative staff appraisals and practice away day had been put on hold to ensure effort was focused on the smooth introduction and training of staff in the new system. Both clinical and administrative staff commented positively about the system's safety and ease of use.

For patients on end of life care, do not attempt resuscitation (DNAR) decisions were communicated to the out of hour's service (OOH) and London Ambulance Service via the 'Co-ordinate My Care' website.

Consent to care and treatment

The practice had a comprehensive consent policy which defined consent, how to give it, when it was and was not necessary, the documentation of consent decisions, consent during emergency treatment , consent for people with mental health conditions, children and young people and young people aged16-17 and refusal of treatment. Staff understood the policy and confirmed they would always seek consent before giving any treatment.

We found that staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. The staff demonstrated a clear understanding of Gillick competencies when asked about seeking consent. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

For significant procedures, staff recorded a patient's agreement to the procedure and the discussion leading to that agreement. This was done either through the use of a consent form or by recording in the patient's notes that they had given oral consent.

Health Promotion & Prevention

Good

Are services effective?

(for example, treatment is effective)

There was a range of information available to patients in the waiting areas which included leaflets which could be taken away from the practice.

The practice offered all patients in the 45-74 age group a health check with the Health Care Assistant who referred patients to a GP if any potential health concerns were detected. For example, patients were automatically referred to a GP if they were considered overweight, had high cholesterol, high blood pressure or needed smoking cessation advice. The practice was proud to have the best record in the CCG for the number of these health checks completed for patients. Patients with a learning disability were offered a physical health check and 71 percent had received one in the last 12 months, The checks took place from 1 April to 31 March and in the current year the practice had completed 46 percent so far. The practice's target this year was to achieve at least 80 percent (in line with the CCG target).

HIV testing was carried out by the practice on an ad hoc basis. The practice ran a weekly weight loss group and referred patients to exercise programmes to support this. The practice offered a smoking cessation service every Tuesday between 09:00 -12:00 and 14:30 -16:30 which was available by appointment only. The practice also had an active campaign using text invites to encourage quitters. The number of smoking quitters in the last 12 months (April 2013 to March 2014) was 29 and the practice was 5th in the CCG area out of a total of 28 practices. The quit rate was 39 percent and 35-70 percent quit rates were considered standard. The practice previously hosted an alcohol counselling service, which was shortly to be re-instated with the appointment of a new counsellor.

The practice hosted a full time contraception and sexual health services clinic. The clinic offered a range of services including contraception, smears and sexually transmitted infections (STI) testing. The clinic was open evenings and weekends.

The practice's performance for cervical smears was 69 percent in 2012 which was better than the average of 65 percent for the CCG area. The practice was in the top 10 compared with a total of 31 practices in the area. The Family Health Service (FHS) hosted at the practice sent out two invitations for a smear test. If they did not get a response they alerted the practice and they sent a third letter themselves. If a response was not forthcoming they would complete an exception report or deduct the patient from the registration list if it was clear that the patient has moved away. They also backed this up by sending occasional text messages. We were told that securing attendance could be challenging because of the transient population served by the practice.

The practice offered a full range of immunisations for children. According to NHS England data for 2013/14, the percentage receiving a vaccination at the practice was below the average within the CCG area for the majority of vaccinations in the 12 and 24 months age group; and above the average within the CCG area for the majority of vaccinations in the five years age group. We were told that earlier in the year reminders for vaccinations were not sent out for several months during the practice's migration to a new computer system, so to address this and secure improved uptake the practice had introduced a 'birthday card' system to remind parents about vaccinations.

Flu vaccination was offered to patients over the age of 65, those in at risk groups and pregnant women. Vaccinations were taking place during the week of our inspection. Patients could attend a walk in clinic or book by appointment if they preferred. Human Papilloma Virus (HPV) vaccination was offered to teenage girls. The practice offered a travel vaccination service.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and a survey of 205 patients undertaken by the practice's Patient Participation Group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who would recommend their GP Surgery. The practice was also above average in the CCG area for its satisfaction scores on consultations with doctors and nurses, with 93 percent of practice respondents saying the GP was good at listening to them and 83 percent saying the GP gave them enough time. The practice had received a three star rating on the NHS Choices website for dignity and respect. Where negative comments had been posted in this respect, the practice had posted a response on the site, apologised for any dissatisfaction caused and offered a meeting or telephone call to discuss the matter further.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 39 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were welcoming, efficient, helpful and caring. They said staff treated them with dignity and respect, listened to them and met their needs. They felt the practice was safe, clean and hygienic. Eight comments were less positive and these were mainly about the difficulty sometimes in getting an appointment and getting through to the surgery on the telephone during busy times.

We also spoke with seven patients and two representatives of the PPG on the day of our inspection. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Nothing of a confidential nature was discussed in front of other patients while we were present.

Staff told us if they had any concerns or observed any instances where patients' privacy and dignity was not being respected they would raise these with their manager in the first instance. They were aware of the practice's whistleblowing policy which provided a formal process for raising such concerns.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice positively in these areas. For example, data from the national patient survey showed 76 percent of practice respondents said the GP was good at involving them in decisions about their care and 82 percent felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area.

Patients we spoke to 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 ask questions and make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also mostly positive and aligned with these views. However, two patients mentioned that whilst they were listened to they felt their appointments were rushed.

Staff told us that translation services were available for patients whose first language was not English to help them with their communication needs. We saw notices in the reception areas informing patients this service was

Good

Are services caring?

available. We saw also that the practice's website had a translation facility for each page in a wide choice of languages. In addition staff at the practice spoke French, German, Greek and Slovak.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were positive about the emotional support provided, and this was reflected in the comment cards we received. Patients who experienced bereavement of a family member described significant levels of additional and personal support from their doctor, which they had found helpful. This included impromptu and out of hours home visits. The doctor also supported and arranged counselling for the bereft patient.

The practice provided appropriate support for end of life care. There were close links with the palliative care nursing team who were involved in regular multidisciplinary team meetings at the practice and visited the practice to provide support to terminally ill patients and their relatives and carers. GPs worked with the palliative care nurses to manage the care of patients receiving end of life care, including pain management and advice. The practice was Gold Standards Framework (GSF) accredited, a national standard of care for people nearing the end of life. The review of patients on the palliative care register was a standing item on the agenda for monthly clinical meetings and we saw the minutes of meetings which confirmed this.

Notices in the patient waiting room, also signposted patients to a number of support groups and organisations. There was also bereavement advice on the practice website. The practice's computer system alerted GPs if a patient was also a carer.

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. Patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and in most respects were happy with the service provided. This was confirmed in patient surveys conducted through the practice's patient participation group (PPG). Where necessary, the practice took action to address areas identified for improvement. The PPG was set up as part of a patient participation direct enhanced service (DES) to enable patients to provide feedback about the service and contribute to improvements in service delivery. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. These included the introduction of an online booking system for appointments, improved disability access (the installation of braille indicators in the lift), the introduction of commuter appointments and an evening clinic once a week for patients unable to attend earlier in the day.

The practice engaged with commissioners of services and other providers to co-ordinate and provide integrated care which met the needs of the different population groups it served. One of the GP partners and the practice manager represented the practice at CCG meetings. As part of the CCG network arrangements the practice engaged regularly with other practices to discuss local needs and service improvements that needed to be prioritised. We saw the latest quarterly network plan review document which included a review of a referral reduction plan covering specialty clinical areas including cardiology, dermatology, urology and ENT. The practice participated in a number of local enhanced services (LES) and direct enhanced services (DES) schemes to improve the management and delivery of care to specific patient groups. For example, the practice was involved in an enhanced service scheme reviewing discharges to see whether hospital admissions could have been avoided.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments. For urgent appointments this was not always possible but patients understood that they may have to see a different GP if they wanted an appointment on the day. The practice recognised this was previously an area for improvement due to high locum use, and were in the process of changing its staffing structure to better meet patient needs. They had already employed a salaried doctor, which had reduced locum use significantly and were reviewing the need for another. In addition they were in the process of allocating named GPs for each patient, and were reviewing the patient list to ensure the appropriate GP was allocated.

The practice was able to offer a choice of male or female doctor in most cases if this was requested. Most patients we spoke with said they were usually able to see the same GP, although some said this was not always the case and one patient told us they missed the continuity of seeing the same GP. Longer appointments were available for people who needed them and those with long term conditions. One of the GP partners made fortnightly home visits to patients in local 'extra care' accommodation. Many of these patients had complex needs and half of them suffered from dementia.

The practice had achieved and implemented the Gold Standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients' and their families' care and support needs.

The practice provided GP led diabetic clinics and the practice nurse ran chronic obstructive pulmonary disease (COPD)/asthma clinics.

For older patients and patients with long term conditions home visits were available where needed and longer appointments were provided when needed.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients with complex needs who were at risk of admission to hospital were referred to a local CCG network based 'Virtual Ward'. The practice referred patients to a multidisciplinary older people's rapid access (OPRAC) service for assessment and treatment. Care plans had been introduced for people with long term conditions which included setting patient goals and the provision of 20 minute appointments. Annual health

Good

Are services responsive to people's needs?

(for example, to feedback?)

checks were provided for patients with learning disabilities. There were no increased services for homeless people but the practice offered the same service to these people as other patients.

The practice ran a joint clinic with health visitors for six-eight week baby checks and provided a fast access service for babies to see a GP. Sexual health was promoted by hosting the West London sexual health clinic. The practice had links to a local domestic violence support unit and one of the partner GPs was the designated practice domestic violence champion. A primary care mental health worker held a clinic for one afternoon a week to provide support to discharged patients and facilitate referrals. There were close links with a local personality disorder consultant for e-mail support and advice and there was daily use of a telephone psychiatry hot-line to a consultant for psychiatric advice. In addition the practice facilitated patients' access to the local 'Improving Access to Psychological Therapies (IAPT) programme.

The practice had access to interpreter and translation services and the website has a translation facility in a wide range of languages.

The practice had an equal opportunities policy. We heard that a member of the patient participation group (PPG) had recently provided training in visual impairment and had also carried out an evaluation of the practice's website from a visually impaired perspective. The evaluation model was transferrable to other access groups which the practice could use for further reviews. We noted from the 2013/14 PPG report the group had gathered basic demographic data on sex, age, priority clinical areas and ethnicity in order to help form a representative patient group. Poster advertisements were displayed in the practice and on the website to encourage new membership from unrepresentative groups. The practice also encouraged participation from the local extra care home to which it provided GP services. The revised group for 2014 had a wider mix of representatives as a result.

The premises and services had been adapted to meet the needs of people with disabilities. There was ramp access at the front entrance for wheelchair users, toilets for patients with a disability and braille indicators in the lift. There was an induction loop at the reception area.

Access to the service

Appointments were available from Monday - Friday 08:15-18:30. Appointments were also available up to 20.00 on Wednesday evenings when the practice ran a commuter clinic. Emergency appointments were made available daily for both the morning and afternoon sessions. Pre-bookable appointments were available up to three weeks in advance in person by phone or online. Telephone appointments were provided for patients who were unable to book a same day appointment and requests for this were triaged by the duty doctor. If patients were unable to obtain an appointment and felt their medical condition needed assessing that day, they could go to the practice between 15:30 and 16:00 and be seen when a doctor was available. However, they were warned to expect to wait. Patients were advised to consider an appointment with a practice nurse rather than a doctor as the nurses were qualified to deal with many conditions and patients may be seen more quickly.

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. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Data from the national patient survey showed the practice was rated among the best for respondents who describe their experience of making an appointment as good. 91 percent were able to get an appointment to see or speak to someone the last time they tried and 90 percent said the last appointment they got was convenient. Both of these scores were above the average for the CCG area. The practice's extended opening hours on Wednesdays was particularly useful to patients with work commitments. This was confirmed in the minutes of the June 2014 patient participation (PPG) meeting which noted that the evening commuter clinic was proving popular.

The views from patients we spoke with and who completed comment cards were mostly positive about access to the service. However, there were some negative comments about the difficulty sometimes in getting an appointment and getting through to the surgery on the telephone during

busy times. In addition the key issues for improvement from the latest patient survey conducted by the practice's patient participation group (PPG) included telephone access, appointments, waiting times and reminder systems. The national patient survey also showed waiting times as an area where the practice could improve given that 41 percent of respondents said they usually wait 15 minutes or less after their appointment time to be seen.

The action plan in response to the PPG survey included a review of the functionality of the telephone system; ensuring reception was open at all times in core hours and that patients could collect prescriptions and test results all day; making greater use of text messaging; steps to improve waiting times (for example, varying the length of appointments to anticipate when patients might need longer and the introduction of 'catch-up' slots within each GP surgery to help reduce over-running); and the introduction of early afternoon GP clinics for patients who tend to arrive early to make appointments. We saw from the minutes of the June 2014 PPG meeting that these actions had been implemented and further proposed action was agreed including the pilot of an early morning pre-booked telephone consultations clinic (7.00 - 8.00am) and the introduction of a Saturday morning GP clinic. It was also agreed that a gradual change of the balance between pre-bookable and on the day appointments should be introduced. This would allow for greater use of online booking facilities and also reduce telephone demands at peak times when patients were trying to make appointments. Alongside this change, staff would be trained to help patients navigate the service to ensure that GP time was not being used inappropriately.

Richford Gate Primary Care Centre was located in a four-level building including a basement level housing a pharmacy, sickle and thalassaemia clinic and a sexual health clinic. The building was shared with Central London Community Healthcare NHS Trust (CLCH). The practice was situated on the second and third levels of the building with the majority of services for patients on the second level. Lift access was provided to the second and third levels. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system. There were copies of the practice's complaints leaflet in the waiting area which set out the complaints procedure and timescale and provided information about who to contact for additional advice. There was also a suggestion box in the waiting room where patients could make suggestions or comments which the practice reviewed daily. Alternatively patients could submit a formal, written complaint. There was also information about making complaints on the practice website. None of the patients we spoke with had needed to make a complaint about the practice.

We looked at the eight formal written complaints received by the practice in the last twelve months and found these were appropriately handled and dealt with in a timely way. The practice reviewed all complaints to identify themes or trends. We saw the analysis of written complaints and feedback received from comment cards and the NHS Choices website. This included a summary of the complaint, action taken and lessons learned. The key themes related to access to appointments and waiting times and we saw these were passed to the practice's patient participation group (PPG) for review.

The practice was unable to investigate the comments posted on NHS Choices as they were anonymous. However, the practice had in most cases posted a response on the site, apologised for any dissatisfaction caused and offered a meeting or telephone call to discuss the matter further.

We saw that lessons learnt from individual complaints had been acted upon and staff told us that these had been drawn to their attention where appropriate. For example, we heard from staff that as a result of a complaint the process for late arriving patients was changed to ensure that those who arrived 10 minutes late or more should be informed that they may need to be rebooked due to their late arrival. The receptionist would then check with the healthcare professional if they were able to see the patient and inform the patient of their response.

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 ethos which involved putting patients first and was committed to providing them with the best possible service. Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England. The practice's mission statement included the following aims: "To provide good quality primary medical care for all patients registered at the practice; to meet the requirements of the general practitioner contract; and to provide professional satisfaction for all who work in the practice". We spoke with 10 members of staff who understood and were committed to these aims and were clear about responsibilities in relation to them.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the computer system within the practice and in hard copy. There was staff handbook containing appropriate human resource policies which were last reviewed in October 2013. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff and we saw were subject to regular review.

The practice was accredited for ISO 9001, an internationally recognised standard for the quality management of businesses. The practice's accreditation was audited annually and we saw the April 2014 surveillance report. This recognised that despite significant major restructuring of the NHS, the practice's introduction of a new computer system and the retirement of two GPs there had been a wide range of improvement initiatives and positive outcomes had been observed during the visit. The practice was seen to maintain an engaging environment for patients and staff with a very strong sense of ownership and team work. The operational procedures in the practice's ISO 9001 quality manual supported the practice's governance processes.

The practice held monthly clinical governance meetings. We looked at a sample of minutes from four meetings in the last nine months and found that performance, quality and risks had been discussed and there was ongoing review of individual patients and groups of patients with specific conditions.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that QOF data was regularly discussed at monthly clinical meetings and follow up action agreed to maintain or improve outcomes. For example, patients on the practice's dementia register were due a test within six months of a new diagnosis. The practice was seven diagnoses below the target (6 of 13 completed) and put in place steps to ensure this target was met, including opportunistic testing when patients attended for flu vaccinations and more direct invitations by letter and text messaging.

The practice took part in local peer review with neighbouring GP practices as part of the CCG's network arrangements. We saw the latest quarterly network plan review document which included a review of a referral reduction plan covering specialty clinical areas including cardiology, dermatology, urology and ENT. Lead GPs were identified and action plans drawn up to reduce referrals within set targets for each of these areas.

The practice had completed a number of clinical audits. Examples of audits undertaken in the last 12 months included audits of cervical screening smears, International normalisation Ratio (INR) monitoring for patients who had warfarin as a repeat prescription, unscheduled A&E admissions and vitamin D supplementation.

The practice had appropriate risk management processes in place. These included a business continuity plan to respond to and manage risks in the event of major disruption to the service. There were regular health and safety risk assessments of the practice environment and equipment. The practice regularly monitored and reviewed risks to individual patients and updated care plans accordingly.

Leadership, openness and transparency

The practice had a clear management structure with designated leads for clinical and administrative areas. For example, the practice nurse was the lead for infection control and there were GP leads for child protection and prescribing. All staff had job descriptions and clearly defined roles which they knew and understood. There were

Are services well-led?

Good

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

clear HR policies and procedures to support staff. The Practice partners fostered an open and learning culture and staff commented positively on the support they received.

Although there were monthly clinical meetings which were documented, meetings for administrative staff were held on an ad hoc basis to brief staff on important developments and were not minuted. This meant that information relating to agreed action might not be readily retrievable to enable progress to be reviewed from one meeting to another. However, staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues on a day to day basis and in regular informal meetings with their managers. This included discussion about learning and development needs. They were also kept up to date through regular emails from the practice manager. We were told that the practice held a team away day every year to do team building and look at future practice developments. However, because of the impact of the introduction of a new clinical computer system the away day had not been held this year, but one was planned early in the new year.

The practice manager was responsible for human resource policies and procedures which were contained within the staff handbook that was available to all staff. We reviewed a number of policies, for example capability, disciplinary and grievance procedures, training policy and management of sickness which were in place to support staff. The handbook also included sections on dignity at work, harassment, data protection and whistleblowing. Staff we spoke with knew where to find these policies if required. The practice's ISO 9001quality manual also contained a range of operational procedures. These included training and appraisal, procedures for nursing such as the running of the diabetic clinic and maintaining vaccine refrigeration temperatures, and procedures for administrative staff, including key receptionist procedures for handling processes relating to for example, appointments, medical records, test results, booking home visits, collection of specimens, telephone call answering and registering patients.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the analysis of the feedback received over the last twelve months and saw that key themes related to access to appointments and waiting times. We saw these were passed to the practice's patient participation group (PPG) for review and action planning to improve performance in these areas. We noted from the group's 2013/14 action plan a number of steps taken including longer reception opening times, a new text messaging service which enabled patients to cancel appointments by text and 'catch-up' slots within each GP surgery to help reduce over-running.

The PPG was an active group and was continuously seeking to expand in size and extend the representation from various population groups. The 2013/14 PPG report showed the group consisted of nine active members. The ages ranged from 35 to 82 with five female and four male representatives. Within the group they had three working professionals, two retired members, one mother with young children, one unemployed, one volunteer and a freelance professional. Six members were of British or mixed British ethnicity, two members were white other ethnicity and one member was of black other ethnicity. The PPG carried out annual surveys and met every six months. The PPG's annual report, including the results and actions agreed from patient surveys, was available on the practice website. The group's action plans were discussed and agreed by the practice partners. We spoke with two members of the PPG on the day of the inspection. They were very positive about the way the practice engaged with the group and were complimentary about the quality and safety of the services provided to patients by the practice.

The practice gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us their managers were very approachable and they felt free 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 whistle blowing policy which was available to all staff in the staff handbook. All staff we spoke with were aware of the policy and the process to follow if they had any concerns.

Management lead through learning & improvement

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 supported them to maintain their clinical professional development through training and mentoring. We looked at the records of 16 staff and saw that regular appraisals took place which included a personal development plan. Appraisals for non-clinical staff had been on hold in the current year to focus on the introduction and training for a new clinical computer system. However, their learning and development needs had been discussed and agreed and they had continued to undertake relevant training. Staff told us that the practice was very supportive of training and that they had away days to foster team building and discuss future practice development.

The practice was a GP training practice and at the time of the inspection there were three registrars on placements at the practice. We spoke with all three during the inspection. They told us they had undergone a week's induction, which was varied based on their individual needs. They shadowed their GP trainers until they were comfortable to see patients themselves. They had weekly tutorials, some as a group and some on a one to one basis, and felt these worked well. They contributed to the planning of the tutorials.

They praised the support they received from both clinical and administrative staff and felt the practice was focused on excellent patient care. They were able to attend practice clinical meetings and one had attended a CCG meeting as part of their learning and development.

The practice had completed reviews of significant events and other incidents and shared these with staff via meetings and email communications to ensure the practice improved outcomes for patients. For example, in one case there was a delay in the diagnosis and treatment of a patient due to a number of procedural shortcomings. As a result the practice put in place protocols for handling results faxed by paper (rather than coming in electronically to ensure results would be visible to the whole team). It was agreed that when a doctor called from a hospital they must be put straight through to the appropriate or duty GP who could then decide if they need to take the call urgently, or if it could wait. In addition the administrative office kept a log of all tasks they had been asked to carry out such as result chasing, and informed the appropriate GP if the task had been unable to be completed for any reason.