The Bush Doctors

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced, comprehensive inspection of The Bush Doctors on 9 October 2015. The practice is located in Shepherds Bush in West London and provides care to 11,850 patients.

We rated the practice as Requires Improvement overall for the quality of its services. The practice was rated as Good for being caring and as Good for being responsive to the needs of its patients. However improvements were required to ensure the practice was providing fully safe and effective care and was well-led.

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients who used services were assessed and the practice had systems to address risks in relation to infection control, medicines management and emergency situations.
- The practice had developed the service and skills of the staff team to meet patients' needs. We found that care for long term conditions such as mental health was managed effectively and was provided in partnership with other specialist services.
- Patient survey results were in line with local and national averages for the quality of care and consultations. The practice scored better than other practices locally for the extent to which patients felt involved in decisions about their care. Patients we spoke with were very positive about the quality of care they received.
- The practice reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified.

However there were also areas for improvement. Importantly, the practice must:

- Carry out and document all necessary recruitment checks including checking proof of identity of new members of staff

Summary of findings

- Ensure that all staff members receive an annual appraisal and support to develop in their role. The practice must also ensure that clinical team members have opportunities for formal supervision.
- The practice must ensure that the risk to patients has been properly assessed in relation to managing poor staff performance.
- The practice must ensure that informed consent is documented before undertaking minor surgical procedures.

In addition the provider should:

- Consider further action to address late running of appointments. This had occurred fairly regularly at the practice and affected patients' experience of the service.
- Provide clear information for patients about the length of any likely delays to appointments.
- The practice should have systems in place to ensure that the clinical team are aware of safety alerts and are acting on these as required.
- The practice should ensure that all staff are reporting incidents consistently and in line with practice policy.
- The practice did not keep records to show that staff had satisfactorily completed their induction.
- The practice contingency plan should be tailored to reflect the specific risks affecting this practice.
- The practice should ensure that audit recommendations are implemented effectively.
- The practice should consider ways to encourage patients age 40-74 to attend for a health check.
- Review opportunities for the wider staff team to meet to reflect on learning and good practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons learned were communicated to support improvement. The practice ensured that all staff had been trained on safeguarding vulnerable adults. There were GP leads for child protection and safeguarding vulnerable adults and staff understood their duty to report concerns promptly.

Risks to patients who used services were assessed and the practice had systems to address risks in relation to infection control, medicines management and emergency situations. The practice contingency plan did not address some of the particular risks facing the practice.

The practice had recruitment processes in place and sufficient staffing levels. The recruitment process was not fully documented and satisfactory proof of identity was not recorded in all cases before new members of staff started work at the practice. The practice did not keep records to show that new staff had satisfactorily completed an induction.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed that patient outcomes were generally at or above average for the locality. However, the practice was finding cervical screening and flu vaccination uptake challenging despite the practice actively targeting this as an area for improvement.

Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice carried out clinical audit but it was not clear that recommendations had always been implemented effectively. Staff worked with multidisciplinary teams and shared information appropriately. The practice was not always documenting patients' informed consent before carrying out minor surgical procedures.

Staff had received training appropriate to their roles but not all staff had received an appraisal and there were limited opportunities for clinical supervision.

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Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided emotional support to patients experiencing bereavement and their carers and followed the Gold Standards Framework to support patients nearing the end of life.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients were able to make appointments with a named GP, 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.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice aimed to provide high quality care to patients whatever their circumstances. This was reflected in day to day practice and engagement with commissioners and providers. Staff were clear about the practice ethos and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and the GP partners held regular governance meetings. However, the practice was not effectively monitoring that the staff team always acted in line with practice policies, for example in relation to significant event reporting and recording consent for minor surgery.

There were systems in place to monitor and improve quality and identify risk, for example the practice had undertaken detailed planning to move to larger more suitable premises.

The practice proactively sought feedback from patients and the patient reference group was active. However, waiting times in the practice had been a long running issue and had not yet been successfully addressed.

Summary of findings

Staff had received inductions, and most had received an annual appraisal and performance review within the last 12 months. However staff said that there could be more opportunities to meet and reflect as a team.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Every person aged over 75 had a named GP.

We found the provider was responsive to the needs of patients in this population group and achieving good outcomes of care and treatment. However, the provider was rated as requires improvement for providing safe and effective services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients with complex long term conditions had a named GP and a structured annual review to check that their health needs were being met and to review treatment and medicines. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk, for example, with a high number of A&E attendances. The practice ran regular safeguarding meetings with health visitors and social care

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professionals to ensure that concerns were followed-up and referred appropriately. The practice offered an on-site baby clinic run jointly with the health visitors. The baby clinic was held in a separate part of the building away from the main reception and waiting area.

Immunisation rates were high for standard childhood immunisations at 24 months and five years. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

We found the provider was responsive to the needs of patients in this population group and achieving good outcomes of care and treatment. However, the provider was rated as requires improvement for providing safe and effective services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care 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 that reflects the needs for this age group.

We found the provider was responsive to the needs of patients in this population group and achieving good outcomes of care and treatment. However, the provider was rated as requires improvement for providing safe and effective services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had informed vulnerable patients about how to access various support groups and voluntary

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organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice maintained a register of people with learning disabilities. One of the GPs and the practice nurse took the lead for learning disabilities to provide continuity of care. People with learning disability received an annual health check with the nurse. Practice documentation confirmed that people were receiving health checks and treatment in line with their assessed needs.

We found the provider was responsive to the needs of patients in this population group and achieving good outcomes of care and treatment. However, the provider was rated as requires improvement for providing safe and effective services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

We found the provider was responsive to the needs of patients in this population group and achieving good outcomes of care and treatment. However, the provider was rated as requires improvement for providing safe and effective services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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What people who use the service say

The 2014/15 National GP Patient Survey results showed that patients were happy with the quality of care they received. The practice was performing markedly better than the local area average on a range of scores relating to the quality of consultations with doctors, how well doctors and nurses listened and explained things and the extent to which patients felt involved in decisions about their care. However, the practice scored lower than the local and national averages for questions on the experience of making an appointment and waiting times after arriving at the surgery.

The practice had recruited a patient reference group and conducted its own more detailed patient survey in March 2013 using a recognised patient satisfaction questionnaire and taking into account the patient reference group's comments. The issues raised by the survey included the appointment experience, seeing a preferred GP, the quality of the waiting area and waiting times.

We spoke with eight patients who used the service and received written comment cards from a further 19 patients. This feedback reflected the survey findings with patients commenting very positively on their experience of treatment. Several patients who had used the service over a period of time, for longer-term or serious health conditions praised individual doctors and the practice nurse for their skill, attentiveness and support.

However, on the day of the inspection we saw that appointments were running up to an hour late with little information for patients about the likely length of delay. This uncertainty created frustration.

Areas for improvement

Action the service MUST take to improve

The practice must

- Carry out and document all necessary recruitment checks including checking proof of identity of new members of staff
- Ensure that all staff members receive an annual appraisal and support to develop in their role. The practice must also ensure that clinical team members have opportunities for formal supervision.
- The practice must ensure that the risk to patients has been properly assessed in relation to managing poor staff performance.
- The practice must ensure that informed consent is documented before undertaking minor surgical procedures.

Action the service SHOULD take to improve

The practice should:

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- The practice did not keep records to show that staff had satisfactorily completed their induction.
- The practice contingency plan should be tailored to reflect the specific risks affecting this practice.
- The practice should ensure that audit recommendations are implemented effectively.
- The practice should consider ways to encourage patients age 40-74 to attend for a health check.
- Review opportunities for the wider staff team to meet to reflect on learning and good practice.

The Bush Doctors

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 a second CQC inspector. The GP was granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to The Bush Doctors

The Bush Doctors general practice is located in Shepherds Bush in West London. The practice operates from a single site, providing NHS primary medical services through a General Medical Services contract to 11,850 patients in the local community. The practice population has a higher proportion of younger adults than average, lower proportions of older people and children and is ethnically diverse. The local area has relatively high levels of deprivation compared to the English average.

The practice staff team is comprised of five GP partners, three salaried GPs, two practice nurses, two healthcare assistants, a practice manager and a team of reception and administrative staff. Patients can usually book appointments with a male or female GP.

The practice is open Monday to Thursday from 07:00 until 20:00 and on Friday from 07:00 until 18:00, closing for an hour at noon during the week. The practice is also open on Saturday mornings. Walk-in and next day appointments for more urgent health problems are available every weekday morning. The practice has opted out of providing out-of-hours care and signposts patients to local out-of-hours primary care and emergency services.

Why we carried out this inspection

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

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.

How we carried out this inspection

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

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

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

- Older people

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked the Clinical Commissioning Group, the NHS England Local Area Team for Hammersmith and Fulham and the local Healthwatch to share what they knew.

We carried out an announced visit on 9 October 2014. During our visit we spoke with a range of staff including two GP partners, a sessional GP, a practice nurse, the practice manager, two health care assistants and one administrative staff member. We spoke with eight patients who used the service and we reviewed Care Quality Commission (CQC) comment cards left by 19 patients sharing their views. We observed how people were greeted during our visit and viewed the premises, emergency equipment, medicines storage and infection control arrangements. We reviewed a range of documentary information including practice policies and procedures, complaints and incidents, audits, records of staff training and recruitment checks, performance monitoring information and health information and advice leaflets. The GP member of the inspection team also reviewed 15 patient notes.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had systems to monitor safety and respond to identified risks such as reported incidents, complaints received from patients and national patient safety alerts. The clinical staff we spoke with understood their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where incidents and complaints were discussed and reviewed.

The practice had systems in place to keep patients safe, including appropriate management of medicines, maintenance of the premises and equipment and records and information management.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the significant events that had occurred during the last 12 months. The practice had an electronic template that staff used to record significant events which they then forwarded to the practice manager for further investigation. Contrary to practice policy, administrative staff were not completing the template but instead reported any incidents verbally to the practice manager.

Significant events were discussed at weekly practice meetings and the notes shared with clinical staff. We were given examples of changes made as a result. In one case, the practice had responded to a hospital request for a list of prescriptions for a patient with inaccurate information. As a result, the practice had changed its process for responding to such requests to ensure that repeat medicines and all medicines prescribed in the last three months were included on the list and this was checked by the duty doctor before being sent.

All clinical staff were individually registered to receive patient safety alerts by email. The practice manager told us she was responsible for taking action to implement alerts where appropriate, for example any alerts relating to equipment. Individual staff members were responsible for acting on alerts related to clinical practice. The practice did not have systems in place to confirm that staff had read safety alerts, so for example, recent alerts were not routinely discussed amongst the staff team at meetings.

Reliable safety systems and processes including safeguarding

The practice had policies and procedures to protect children, young people and vulnerable adults from abuse. The practice had appointed individual GPs to lead on safeguarding. Staff were able to tell us which GP was leading on child protection but were unclear about the lead for safeguarding vulnerable adults. Staff members we spoke with informed us that they would report any concerns about a vulnerable adult to a GP partner without delay. We were told of one example where staff had been concerned about a patient with mental health problems who was possibly being exploited by a 'friend'. The practice shared these concerns with the local authority which was investigating the abusive nature of the relationship and took action.

We looked at training records which showed that all staff had been trained in child protection with clinical staff receiving child protection training to "level 3". Staff had also been trained on safeguarding vulnerable adults within the last year. Information about child protection and safeguarding procedures was accessible to staff, for example a summary chart was displayed in the treatment rooms.

Vulnerable patients were identified on the practice's electronic records system. The system alerted staff to any relevant issues when patients attended appointments, for example children subject to child protection plans. Any safeguarding concerns about patients raised by other health and social care agencies were reviewed within 24 hours. Open safeguarding cases were discussed at the weekly business meeting.

The practice provided a member of staff to act as a chaperone in consultations if patients requested this. Information about chaperones and how to request one was displayed in the waiting area. We reviewed the chaperone policy which included some direction for staff about the role. We spoke with the health care assistant who

occasionally acted as a chaperone. They understood the role and how to carry it out appropriately and had undergone Disclosure and Barring Service criminal records checks.

The practice had a whistleblowing policy. The staff we spoke with understood what was meant by whistleblowing and their obligation to report any concerns. Staff could readily access the policy if they needed to refer to it.

Medicines management

The practice held a stock of vaccines. It also stored a small number of medicines for use in an emergency. We checked the medicines and vaccines storage arrangements and found these were secure and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff were following this policy, for example checking and keeping a record of the vaccines fridge temperature in line with national guidance.

It was part of the practice nurses' role to administer vaccines. The nurses were authorised to provide this service through written patient group directions. We reviewed these documents which were clear about which vaccines and immunisations were included and signed by a doctor, a pharmacist and the nurses.

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

The practice reviewed its prescribing performance relative to local and national norms and against guidelines. The practice had been focusing on its prescribing of antibiotics and NSAIDS (a class of anti-inflammatory medicines). Prescribing was generally meeting expectations although the prescribing of first line antibiotics (that is, the antibiotics that GPs are recommended to prescribe first) remained an area for continued focus.

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. We checked five anonymised patient records which confirmed that the procedure was being followed.

We reviewed the practice repeat prescribing policy. All prescriptions were reviewed and signed by a GP before they were given to the patient. Patients could request repeat prescriptions in person and online. One of the receptionists was responsible for issuing authorised repeat prescriptions and had been trained on the practice repeat prescribing protocol. Repeat prescription requests were shared out to the GPs for authorisation and signature. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us the practice always appeared to be clean.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the lead had carried out training with other members of staff and had carried out an audit of infection control within the last six months.

The practice had an infection control policy. This was comprehensive and covered for example, the disposal of sharps and the management of instruments, biological substances, waste management and hand washing. There was also a protocol for needle stick injury. The practice used single-use equipment wherever appropriate. The practice had updated its infection control procedures to reflect national infection control guidelines and tools. Personal protective equipment including disposable gloves was available for staff to use. Staff told us that the practice was well supplied and they were never short of single use items or personal protective equipment.

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

The practice contracted with a cleaning company with set cleaning schedules and records of monthly, weekly and daily tasks. Cleaning was carried out in line with current national guidance, for example in relation to cleaning materials and equipment.

Requires improvement

Are services safe?

The practice leased space within a larger shopping centre and the centre's building managers were responsible for assessing and addressing any risks in relation to Legionella infection. The practice told us they liaised with the centre's building managers and could contact them when necessary.

Equipment

Staff we spoke with told us they had 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. All portable electrical equipment was routinely tested and had last been checked in November 2013. We saw evidence that equipment such as spirometers and blood pressure monitors had been calibrated (that is, checked to ensure that they gave readings that were accurate and reliable) within the last year.

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Staffing and recruitment

Records we looked included evidence that most recruitment checks had been undertaken prior to employment in line with practice policy. Documented checks included qualifications, references, and registration with the appropriate professional body. The practice had also undertaken criminal records checks through the Disclosure and Barring Service for all clinical staff members. However, the practice had not recorded whether proof of identity had been checked for two staff members.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. The practice had an on-call system to help ensure that other staff members could cover unexpected absence. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had an induction programme for new staff and this was confirmed by staff members we spoke with. The practice did not keep records to show that staff had satisfactorily completed their induction.

Monitoring safety and responding to risk

The practice had policies and processes in place to assess, manage and monitor risks to patients, staff and visitors to the practice. These included risk assessments in relation to fire safety, checks of the environment, medicines management, staffing, dealing with emergencies and equipment. Essential health and safety information was on display.

The practice used risk assessment in conjunction with the electronic records system to alert GPs to known risks, for example in relation to lone safety when visiting some patients at their home address. Staff knew how to escalate and report incidents where there was a risk to their personal safety. The practice electronic system included a panic alarm and staff knew how to activate this and how to respond if another member of staff was threatened.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and interviews showed that all staff had received training in basic life support within the last two years and knew how to respond to an emergency. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed that it was checked regularly.

The practice kept a small stock of medicines for use in an emergency. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice nurses were responsible for checking whether emergency medicines were within their expiry date and suitable for use and we saw records showing these checks were completed. All the medicines we checked were in date and fit for use.

Requires improvement

Are services safe?

A business contingency plan was in place to deal with a range of emergencies that might affect the daily operation of the practice. Risks identified included power failure, failure of computer systems, adverse weather, unplanned sickness, and access to the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. New and updated guidelines from the National Institute for Health and Care Excellence (NICE), NHS England and the local commissioning group were discussed at the weekly business meeting or less commonly at ad hoc 'clinical' meetings organised with the wider clinical team. Staff we spoke with were familiar with current guidance for common conditions, and were able to access guidelines electronically on the practice's shared drive if they needed to reference these.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and reviewed care and treatment when appropriate, for example, if a patient's condition was not improving as expected. The practice carried out care planning for people with complex and long-term health conditions. The standard care planning template included consideration of the patient's mental capacity, the patient's wishes about their treatment should they become increasingly unwell, the other agencies involved in the patient's care and medicines reviews. We saw examples of reviews carried out by the practice nurse with a patient with chronic pulmonary obstructive disorder (COPD) and a patient with diabetes.

Individual GPs led in specialist clinical areas such as substance misuse, learning disability and mental health. The practice ran a number of specialist clinics such as diabetes and offered minor surgery and family planning including contraceptive implants. The services offered were linked to the needs of the local population.

National data showed that the practice was in line with referral rates to secondary and other community care services. The practice had systems in place to ensure that GPs were able to meet national standards, for example, for the referral of patients with suspected cancers who were referred within two weeks.

Management, monitoring and improving outcomes for people

The team made use of clinical audit, benchmarking and staff meetings to assess the performance of clinical staff and the practice as a whole.

We did not see an annual audit plan for the practice but we were shown a number of recent clinical audits to check that practice was in line with recognised standards and to identify areas for improvement. For example, we were shown audits of retinal screening, prescribing of benzodiazepines (a type of sedative), and prescribing of sitagliptin (a medicine for diabetes). The retinal screening audit was a repeated audit to check that retinal screening rates in the practice had increased. In fact the audit identified a lower screening rate but over a shorter period of time. The recommendation was that the audit should be repeated in two months to provide a full year's data and enable like-for-like comparison. However the practice was unable to produce evidence to show us that this had been done. The audit of benzodiazepines resulted in a recommendation to change the practice prescribing policy for benzodiazepines. We were told this change to practice prescribing had been communicated to the doctors verbally and the practice manager would review the written policy in due course. The practice should ensure that audit recommendations are implemented effectively.

The practice manager showed us the practice's Quality and Outcomes Framework (QOF) results and data collated by the Clinical Commissioning Group of the practice's relative performance on a range of measures. QOF is a national performance measurement tool. The practice performance was generally comparable to similar practices or better in a number of areas. However screening rates were described as a continuing challenge for the practice, with flu and cervical screening rates in particular below target. The practice had changed its approach to flu vaccination this year by signing up to a patient text messaging service and holding weekend and evening walk-in vaccination clinics.

The practice participated in local benchmarking exercises run by the local Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to other similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable to other practices. Clinical audits and data collection exercises were also undertaken as part of the practice participation in the QOF and other contractual requirements.

Requires improvement

Are services effective?

(for example, treatment is effective)

The GP partners had opportunities to reflect on the quality of the service. The mechanism for this was primarily through a monthly 'business' meeting at which clinical cases and safeguarding concerns were also discussed. There were fewer opportunities for the wider clinical team to meet. Salaried doctors and nursing staff said they were informed of key developments affecting their practice for example by email, but they did not attend the weekly business meeting. They said it would be useful to have more opportunities to share clinical practice.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with most mandatory courses such as annual basic life support. The practice manager monitored attendance. The GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Clinical staff were assigned a mentor within the practice. Salaried GPs and the practice nurses were mentored by the GP partners. The health care assistants were mentored by the practice nurse. The staff we spoke with said the practice was very supportive but supervision tended to be informal. Several members of staff thought that more formal supervision opportunities with the GP partners would be helpful.

Most of the wider staff team had received an annual appraisal although these had generally been poorly documented. One member of staff had not received an appraisal for several years and there was no record of how this person's performance and longer term development had been supported.

The practice nurses performed defined duties and were appropriately trained to fulfil these duties, for example, on the administration of vaccines, taking cervical smears and reviewing patients with long-term conditions such as asthma and diabetes.

Interviews and staff files showed that where poor performance had been identified action had been taken to manage this. However, the practice must be able to demonstrate that any risk to patients has been properly assessed in relation to managing poor staff performance.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. The practice manager and doctors reported good working relationships with community services, specialist services and the pathology laboratory service. One of the GP partners was a member of the local clinical commissioning group (CCG) and involved in developing effective health services for the area as a whole. This included work to establish a "federation" of local GPs.

For example there were good links with the community diabetic nursing team. One of the GPs ran a baby clinic at the practice jointly with the health visitors. We were told that patients benefited from access to high quality specialist services nearby, for example an Older Persons Rapid Access Clinic. The clinical staff told us they were able to contact specialist consultants from a range of specialties for advice on the management of specific cases. We spoke with several patients who had used the service over a period of time for longer-term or serious health conditions who praised the continuity of care and access to specialist treatment through the practice.

The practice participated in multidisciplinary team meetings for example, to discuss the needs of complex patients and those with end of life care needs. Some of these meetings were regularly attended by community nurses and decisions were documented in patients' individual care plans.

The practice worked with local substance misuse services to provide safe and appropriate drug replacement therapy to patients with a history of substance misuse. The GPs were aware of the importance of actively promoting recovery from drug dependency with these patients.

The practice communicated with out-of-hours services and was made aware the next morning of any patients who had required care out-of-hours who might need following up. Letters from the out-of-hours service were shared between the doctors each day.

Information sharing

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice communicated with other providers electronically. Electronic systems were in place for making referrals. Discharge letters were distributed to the duty doctor or to an in-box for action. The doctors reviewed each case and amended medicines where necessary; and arranged any follow-up actions, for example to see the patient in the practice.

The practice had systems to provide staff with the information they needed. The practice used an electronic patient record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children and Families Act 2014 and their duties in relation to this legislation. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions and help develop a care plan. Care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Clinical staff understood the Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). When doctors saw a patient under 16, the electronic records system generated a 'pop-up' with the Gillick criteria to help staff assess consent appropriately.

The practice was not always recording patient consent for minor surgery appropriately. Practice policy was that written consent should be obtained and scanned into the patient records. However we found that consent was not always being recorded. We were told this was because the electronic records system had changed and doctors now had to record verbal consent on the system in a different way.

Health promotion and prevention

The practice partners were aware of the needs of the practice population and how population needs were changing. This information was used to help focus health promotion activity.

New patients completed a screening questionnaire and offered a blood pressure check at reception. The receptionists had been trained on how to undertaken these checks and when to refer patients to a GP. Any concerns were referred to a GP for follow up.

The practice used their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. The practice offered NHS health checks to patients aged 40-74 to advise patients about their lifestyle risk factors and symptoms before these developed into more serious health conditions. However the practice advised uptake had been very low. The practice had not planned how they might encourage more eligible patients to attend.

The practice kept a register of all patients with a learning disability who were offered an annual physical health check. We reviewed the records of five patients with learning disability in which health checks and care plans had been documented.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance and had plans to target pregnant women for vaccination against whooping cough as part of their antenatal care. Child immunisation rates at 12 months, 24 months and for five year olds tended to be higher than the local clinical commissioning group (CCG) averages. For example the percentage of five year olds receiving the second MMR (measles, mumps and rubella) injection was 81% compared to the CCG average of 73%. The practice followed up children who did not attend for immunisation in collaboration with the health visitors. The practice invited patients to a range of preventative screening programmes including cervical screening, colorectal screening and retinal screening and again, actively followed up patients who did not attend.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient experience. This included information from the 2014/15 National GP Patient Survey and the practice's own annual patient survey results. The evidence from these sources showed patients were positive about the service. The results for most questions were in line or better than the clinical commissioning group (CCG) and England averages. For example, 95% of practice respondents said the GP was good at listening to them compared to the CCG average of 87%. Ninety-three percent of practice respondents said that the nurse was good at explaining compared to the CCG average of 83%. The practice performed in line with the CCG and England averages for overall satisfaction with 84% of practice respondents saying their overall experience was good or very good.

Nineteen patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice and we spoke with eight patients during our visit. These patients were very positive about the service. Patients described the reception staff, practice nurse and doctors as friendly and caring. Patients had confidence in the clinical skills of the team and the quality of treatment including for serious and longer-term health problems.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy was maintained 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that personal information was kept private. Patients were requested to leave some distance when queueing for reception to protect patient confidentiality.

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 rated the practice well in these areas. For example, data from the 2014/15 National GP Patient Survey showed 88% of practice respondents said the GP involved them in care decisions which was markedly better than the CCG average of 77%.

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

Staff told us that translation services were available for patients who did not have English as a first language and they routinely booked 20 minute appointments if patients needed a translator. We saw notices in the reception areas informing patients this service was available. The website included information about how to book an interpreter in a range of languages.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with and the comment cards we received described the staff as understanding and compassionate. Notices in the patient waiting room and patient website informed patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. Staff told us that if families had suffered bereavement, they were contacted and referred to counselling and bereavement services. The practice followed the Gold Standards Framework when caring for a patient known to be coming to the end of their life. (The Gold Standards Framework is a nationally endorsed model of end of life care.) This approach emphasised the importance of sensitively involving the patient and their families in making decisions about their care at this time.

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 within the context of the broader commissioning priorities for the borough and the socio-demographic profile of the population. The GP partners engaged with other GP practices, local commissioners and other organisations to provide and maintain a service that met patients' needs.

The practice had implemented changes to the way it delivered services in response to feedback from the practice's patient participation group, complaints and patient feedback. For example, the patient participation group had identified late running of appointments and problems with telephone access to the practice as issues. As a result, the practice had undertaken a monthly audit of appointment waiting times and was promoting online booking with additional information in the waiting area and online.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. Services for patients were located on the ground floor. We saw that the waiting area could accommodate patients with wheelchairs and prams although access to the treatment and consultation rooms was more awkward. Accessible toilet facilities were available for patients including baby changing facilities.

The practice was planning a move to larger, more suitable premises and had secured funding for the move. An alternative location at a nearby shopping centre had been considered but rejected because some of the practice's more vulnerable patients could not access that centre.

The practice offered a translation service for patients whose first language was not English.

Access to the service

The practice was open Monday to Thursday from 07:00 until 20:00 and on Friday from 07:00 until 18:00, closing for an hour at noon during the week. The practice was also open on Saturday mornings. Walk-in and next day appointments for more urgent health problems were available every weekday morning. The practice had opted out of providing out-of-hours care and signposted patients to local out-of-hours primary care and emergency services.

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 to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

The practice provided people with complex or more challenging needs with a named doctor. The electronic records system alerted reception staff about patients who usually required longer appointments.

The practice scores for access in the 2014/15 National GP Patient Survey were somewhat lower than the average for the clinical commissioning group (CCG) area. Sixty-two percent of patients reported being able to get an appointment when they wanted compared to the CCG average of 69% and the England average of 73%. The practice offered bookable appointments and emergency consultations the same or next day. The practice scored markedly worse than the CCG and England averages for length of time waiting for an appointment. Only around a third of respondents said they waited less than 15 minutes to be seen compared to the CCG average of 60%. This was also raised by patients in the practice's own survey and our observations during the visit.

The practice had responded to these concerns by auditing patient waiting times. The receptionists were asked to inform patients about any likely delay and there was a board for them to do this. We also saw minutes of meetings where the issue had been discussed and the doctors asked to monitor their time keeping. However, during our visit we saw that patients were not being kept informed of delays at busy times.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

We saw that information was available in the practice leaflet to help patients understand the complaints system. This was displayed in the waiting area and on the practice website. Few patients we spoke with were aware of the process to follow if they wished to make a complaint, but this was because they were generally positive about the service.

Two patients we spoke with were frustrated about the wait to be seen on the day of the inspection which was running at around an hour during the morning. One patient told us they would have to change their plans because of the delay and the other told us they needed to go to work and left before seeing the doctor. Both of these patients discussed the issue with the receptionists but neither wanted to make a formal complaint.

We looked at six complaints received in the last 12 months and found these had been handled in line with the practice policy. We saw that complaints were taken seriously and investigated in a timely way. Patterns were identified if they related to, for example, individual members of staff and followed up through the appraisal and performance process. Where complaints were upheld the practice wrote to the patient, apologised and informed them of actions taken to reduce reoccurrence. Complaints were used as a source of learning and actions shared with the staff team. We spoke with one patient who had used the practice for complex health conditions and had complained about various aspects of the service in the past. This patient told us that the GP partners had listened and responded, for example by providing the patient with an alternative named GP.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients whatever their circumstances. The vision and practice values were used to focus the practice's strategy and business planning and this was reflected in the statement of purpose. The practice partners regularly met to discuss their objectives for the future. The wider staff group was unfamiliar with the partners' objectives and strategy but were able to articulate the practice vision more generally in terms of high quality care for their patients.

Governance arrangements

The practice had developed policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice and paper copies were also available in the first floor office. The policies we saw had been reviewed within the last twelve months. The members of staff we spoke with were clear about their own roles and responsibilities. However, the practice was not effectively monitoring that the staff team always acted in line with practice policies, for example in relation to significant event reporting and recording consent for minor surgery.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was achieving well, including against measures of how well organised they were, for example, on record keeping and obtaining patient feedback. Progress against the QOF and other contractual targets was monitored by the practice manager and the partners.

The practice had arrangements for identifying, recording and managing risks. There were designated leads for specific areas of risk, for example, there was a lead nurse for infection control and named clinical leads for safeguarding.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. The GP partners we met spoke positively about taking advantage of available opportunities to develop primary and integrated services for their patients.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues. We saw from minutes that business meetings were held weekly and included discussion of clinical issues and significant events. However salaried doctors and other clinical staff tended not to attend the business meetings. Key learning points were circulated by the practice manager by email. Some members of staff said that this was an area that the practice might improve upon and there could be more opportunities for the team to meet together and reflect on good practice.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through national patient survey results, its own annual patient survey, reviews on the internet, comment cards and complaints. We looked at the results of the practice's 2014 patient survey. The practice had agreed an action plan with the patient reference group based on the results. The main issue raised was the length of time it took patients to get through to the practice by telephone and waiting times at the practice. The practice had started monitoring the length of time people waited in the practice to be seen, although this remained an ongoing issue.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they were comfortable giving feedback and could discuss any concerns or issues with colleagues and management.

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

Management lead through learning and improvement

Staff told us that they were able to maintain their clinical professional development through training and mentoring. We were told by several members of staff that the practice had encouraged their professional and career

Are services well-led?

Requires improvement

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

development in order to improve services for patients. However not all clinical staff had formal supervision opportunities and not all members of staff had received a formal appraisal. This had impacted on their ability to develop in their role.

The practice management disseminated learning across the staff team primarily through email messaging. For example, we asked staff about specific significant incidents that had occurred within the previous twelve months. Staff members could recall the events in question and the key learning points for their day to day practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to minor surgical procedures. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the provider did not ensure that staff were appropriately supported in relation to their responsibilities. In particular not all members of staff had received an annual appraisal or formal supervision. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the provider did not have effective recruitment procedures in relation to all members of staff. In particular it had not ensured that all required information was available to show that new members of staff were suitable for the role. This was in breach of

This section is primarily information for the provider

Requirement notices

regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.