James O'riordan Medical Centre

Quality Report

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

Summary of findings

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Overall summary

James O'Riordan Medical Centre is a long-established GP practice situated in Sutton, close to the borough boundary with west Merton. It is housed in purpose-built premises especially designed for general practice, and has a practice list of some 5,900 patients. The practice does not provide GP services at any other sites.

During our inspection we spoke with GPs, the Practice Manager, the Practice Nurses (one substantive and one locum), and reception and administrative staff. We also spoke with patients and their families.

Patients and their families had confidence in the treatment and care they received and they praised reception staff for being helpful, caring and polite. It was easy for patients to get through to the practice to make an appointment to see a GP, and the practice worked well with other services to ensure patients' treatment and care was well-coordinated.

The practice had faced some challenges recently with two partners reducing the number of sessions they worked at the practice, the addition of a new partner, and the introduction of the NHS electronic medical information system for patient records. The practice had also had to contend with periods of extended unforeseen leave of absence due to ill health amongst its clinical staff. This impacted on the ability of some patients to see the GP of their choice and had also disrupted some of the practice's plans, for example to establish the virtual Patient Participation Group to help improve its services. The day-to-day operation of the practice was well managed and patients received services that were safe, effective, caring and responsive, although we found some areas for improvement.

The practice was looking to broaden the scope and range of services it provided and to establish more robust systems for monitoring and improving the quality of its services. The practice had identified one of the GP partners to lead on the development of the practice's plans for the future and succession planning.

Older people benefited from one of the GPs having a background in geriatric medicine and sharing their expertise with colleagues. GPs visited people at home where this was required.

The practice held disease management clinics for people with some long term conditions, for example diabetes, to keep them as well as possible. It carried out regular blood monitoring checks for patients reliant on certain drugs that have potentially serious side-effects.

A system was in place for GPs to assess how urgently children and babies needed to be seen. It was the practice's policy to see all babies and children on the same day an appointment was requested for them.

The practice operated extended opening hours to make it easier for working age people to get an appointment to see their GP, and provided a range of services aimed at preventing disease, for example NHS Health Checks.

People in vulnerable circumstances, for example teenage parents-to-be, had access to specialist primary care services. The practice was responsive to people's needs based on religious grounds.

People experiencing poor mental health were referred to appropriate psychological and psychiatric services. The practice completed physical health checks and offered health promotion advice to patients with a serious mental illness.

While situated in Sutton, the practice had elected to be a member of NHS Merton Clinical Commissioning Group (CCG).

The practice is registered with the Care Quality Commission (CQC) to carry on the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Maternity and midwifery services

The practice has not been inspected by CQC before.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Patients received services that were safe, although we found areas for improvement. The provider learned from incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of healthcare acquired infection.

People were protected from the risks associated with medicines, and from unsafe or unsuitable equipment.

GP telephone triage ensured patients were seen within a clinically appropriate period of time and appointments were set aside every day for patients who needed to be seen urgently. The practice was equipped and staff were trained to deal with medical emergencies. Contingency plans were in place to avoid disruption in the service for patients, for example in the event of loss of utilities or incapacity of GPs.

Areas for improvement included:

- The refrigerator in which vaccines were stored was not wired into a switchless socket and was not fitted with a second min/max thermometer independent of mains power.
- The practice did not keep a record of prescription form serial numbers as an added precaution against theft or misuse.
- There was no formal risk assessment in place to support the practice's policy of not completing a Disclosure and Barring Service (DBS) check before appointing non-clinical staff.

Are services effective?

Patients received services that were effective, although we found areas for improvement. We also found an area of good practice. People's needs were met by suitably qualified staff who worked with other services to ensure people received coordinated care. It was clear that the practice was working to recognised best practice guidelines in some areas. However the low level of clinical audit activity meant the practice was not systematically and explicitly confirming the quality of everyday care provided to patients and identifying where there was need for improvement to reach the highest possible standards.

Areas for improvement included:

Summary of findings

- There was little formalised ongoing monitoring of outcomes for patients, including clinical audit.
- Staff appraisal was not being used to enable staff to deliver care and treatment safely and to an appropriate standard, and to engage staff in developing the service.

Are services caring?

Patients received services that were caring. Reception staff were approachable, helpful and courteous. They took care to protect people's privacy and to keep information about them confidential and secure. A chaperone was available on request during intimate examinations. Patients could exercise choice about which hospital they went to for specialist treatment.

Are services responsive to people's needs?

Patients received services that were responsive. Patients could get in touch with the practice easily to make an appointment to see a GP. They could book appointments early in the morning or up to one month in advance, if required. They could also book appointments with a GP of their choice, although they may have had to wait longer for these appointments.

The practice made provisions to meet the diverse needs of the population it served, and used complaints to improve the service.

Are services well-led?

Patients received services that were well-led, although we found areas for improvement. The day-to-day operation of the service was well-managed.

The practice was planning to extend the scope and range of the services it provided and to establish more robust systems for monitoring and improving the quality of its services. There was as yet no overarching strategy for developing the practice in this way, although the practice had identified one of the GP partners to lead on the development of plans for the future and for succession planning.

The practice worked well with the Clinical Commissioning Group (CCG) to monitor and benchmark its performance against other practices in the area.

Areas for improvement included:

Summary of findings

- The practice had fallen behind on its patient survey action plan to increase information for patients about activities, services and events locally that benefit health and wellbeing, and its virtual patient participation group had fallen into disuse.

Summary of findings

The six population groups and what we found

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

Older people
The practice had arrangements in place to respond to the needs of this population group.

GPs were using a recognised tool to assess patients where a diagnosis of dementia was a consideration, and patients were referred to specialist assessment services where appropriate. One of the GPs in the practice had a background in geriatric medicine and shared this expertise with colleagues. GPs visited patients at home where this was required.

People with long-term conditions
The practice had arrangements in place to respond to the needs of this population group.

The practice provided ongoing monitoring of these patients to keep them as well as possible and to prevent avoidable hospital admissions. For example it held disease management clinics for patients with chronic obstructive pulmonary disease (COPD), diabetes, or asthma, and carried out regular blood monitoring checks for patients reliant on drugs that had potentially serious side effects.

Mothers, babies, children and young people
The practice had arrangements in place to respond to the needs of this population group.

Pregnant women valued the antenatal care provided by the practice.

Children and babies were seen as a priority and on the same day on which an appointment was requested.

Best practice guidelines were in place for assessing a child's maturity to make their own decisions and to understand the implication of those decisions when giving consent to treatment.

The working-age population and those recently retired
The practice had arrangements in place to respond to the needs of this population group.

The practice provided services aimed at preventing disease. For example, the practice was completing NHS Health Checks for its

Summary of findings

target population and for new patients joining the practice. It was meeting its target for cervical screening. The practice operated extended opening hours, making it easier for working age people to get an appointment to see their GP.

People in vulnerable circumstances who may have poor access to primary care

The practice had arrangements in place to respond to the needs of this population group.

The practice provided services responsive to people's needs based on religious grounds. It provided support for alcohol detoxification. The practice made referrals to a specialist support service for young people under the age of 20 expecting their first baby.

People experiencing poor mental health

The practice had arrangements in place to respond to the needs of this population group.

There were policies and procedures in place specific to meeting the needs of people experiencing poor mental health, for example around patient confidentiality.

Patients diagnosed as having depression received appropriate assessment of the severity of their depression and appropriate referral to specialist services including psychological therapy.

The practice had taken action to promote the physical health and wellbeing of its patients with a serious mental illness.

Summary of findings

What people who use the service say

We spoke with 13 patients or members of their family, and reviewed 25 comment cards. Patients were complimentary about the service they received, saying the GPs were very good and that reception staff were helpful, caring and polite.

Patients told us it was easy to get through to the practice on the phone and to get an appointment. Some patients we spoke with were content to wait longer to see the GP of their choice, and these patients in particular valued the ongoing relationship that they had with their GP. Others were pleased to get a same-day appointment or an appointment early in the morning so that they would not have to take time off work. One parent we spoke with was very pleased that the practice prioritised children and that their child's appointment had been brought forward because they were worried.

Patients that had been referred to hospital for tests or specialist treatment told us the process had been smooth and that care provided by the practice and the hospital had been well-coordinated.

Areas for improvement

Action the service MUST take to improve

Staff appraisal was not being used to enable staff to deliver care and treatment safely and to an appropriate standard, and to engage staff in developing the service.

Action the service COULD take to improve

The refrigerator in which vaccines were stored was not wired into a switchless socket so that it could not accidentally be turned off, nor was it fitted with a second min/max thermometer independent of mains power.

The practice did not keep a record of prescription form serial numbers as an added precaution against theft or misuse.

There was no formal risk assessment in place to support the practice's policy of not completing a Disclosure and Barring Service (DBS) check before appointing non-clinical staff.

There was little formalised ongoing monitoring of outcomes for patients, including clinical audit.

The practice had fallen behind on its patient survey action plan to increase information for patients about activities, services and events locally that benefit health and wellbeing, and its virtual Patient Participation Group had fallen into disuse.

James O'riordan Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a CQC Pharmacist Inspector, a Practice Manager Specialist Advisor and an Expert by Experience.

Background to James O'riordan Medical Centre

James O'Riordan Medical Centre is a long established GP practice. It is located in Sutton close to the borough boundary with west Merton. It draws patients from the local area and its practice list size is approximately 5,900 patients. Around half of these live in Sutton and half live in Merton.

The practice is in purpose-built premises especially designed for general practice.

In addition to the three male practice GP partners and one female salaried GP, there is a practice manager, two practice nurses, a prescribing clerk and reception and administrative staff.

James O'Riordan Medical Centre refers patients for specialist treatment to St George's Hospital in Wandsworth, Epsom and St Helier Hospitals in Surrey, and Kingston Hospital in Kingston upon Thames, offering patients a choice of hospital. Sutton and Merton Community Services are provided by The Royal Marsden NHS Foundation Trust. South West London and St George's NHS Trust provides community and hospital psychiatric services.

James O'Riordan Medical Centre has elected to be a member of NHS Merton Clinical Commissioning Group (CCG). The CCG is responsible for commissioning health services for the people registered with its 25 member GP practices.

The health of people in Merton is generally better than the England average, and deprivation is lower. While life expectancy is significantly better than the England average, there is wide variation within the borough from east, where life expectancy is lower, to west. James O'Riordan Medical Centre lies in Stonecot ward which is among the 20% least deprived areas in England. Priorities in Merton include reducing the gap in life expectancy between the least and the most deprived parts of Merton, reducing mortality due to heart disease and cancer, addressing major risk factors such as smoking, diet, exercise and alcohol, and improving sexual health.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service, including NHS Quality and Outcomes Framework (QOF) data, and asked other organisations, including NHS England, Merton Clinical Commissioning Group and Healthwatch Merton to share what they knew about the service.

We carried out an announced visit on 20 May 2014 between 8.00am and 6.00pm.

During our visit we spoke with a range of staff, including GPs, the Practice Nurses and Practice Manager, and reception and administrative staff. We looked at the documents the provider could show us about how they run the practice.

We spoke with patients who used the service and their family members. We observed how people were being cared for and spoken to by GPs and staff working at the practice.

Are services safe?

Summary of findings

Patients received services that were safe, although we found areas for improvement. The provider learned from incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of healthcare acquired infection.

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Areas for improvement included:

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Our findings

Safe Patient Care and Learning from Incidents

There was a process in place for reporting, recording, investigating and disseminating learning from significant events, and we saw significant event reports where this had been completed in response to an incident. For example, the practice had put alternative arrangements in place to ensure patients were transferred in a timely way to hospice by the ambulance service. The practice found the planned-transfer-to-hospice protocol in place with the ambulance service was leading to delayed transfers. The Clinical Commissioning Group (CCG) was working to improve the operation of the protocol. The practice had decided to use a different emergency-cancer-admission protocol in the meantime to ensure cancer patients were transferred to hospice in more timely way. This explained why the practice recorded more emergency cancer admissions than the national average.

The practice also implemented learning disseminated by the CCG to improve patient safety and reduce harm. For example it had strengthened its system for tracking pathology specimens sent for analysis following an incident when a courier had had a road traffic accident.

A system was in place for receiving and acting on national safety alerts.

The practice learned from incidents and took action to minimise risks to patient safety. The practice recognised that some staff were reluctant to use the practice's formal reporting process, and was taking steps to ensure all staff and GPs adhered to the forms making up practice's the significant / critical event toolkit.

Safeguarding

GPs and staff employed by the practice were up to date with child protection and safeguarding adults training. The GPs and nurse had completed more advanced child protection training in line with their closer involvement with patients. GPs had Level 3 training and the nurse had level 2 training. The practice had a lead GP for child protection and safeguarding adults to oversee implementation of the practice's safeguarding policies and procedures. Staff were aware of the signs of possible abuse or neglect and knew how to act on any concerns they had to protect people from harm.

Are services safe?

Monitoring Safety & Responding to Risk

The practice set aside a number of emergency appointments for each GP each day in order to respond to patients who needed to be seen urgently. The practice also operated GP telephone triage to ensure patients were seen within a clinically appropriate period of time.

Clinical and non-clinical staff had completed basic life support refresher training, most recently in April 2014. Reception staff demonstrated that they knew what to do in urgent and emergency situations. Emergency equipment including an automated external defibrillator and oxygen gas cylinder were checked regularly to ensure they were fit for use at all times. However the expiry date on the defibrillator pads was not routinely checked. We found the pads were past their expiry date and could not be relied on to function properly. The practice immediately ordered replacement pads and told us that it would treat this failing in its system for checking the emergency equipment as a significant event to identify any further learning from this incident.

Medicines Management

The practice was making use of the clinical pharmacy support offered by the Clinical Commissioning Group (CCG) to ensure medicines were used to achieve the best outcomes for patients so they lead healthy lives and hospital admissions were avoided. For example the practice had acted on benchmarking data provided by the (CCG) and was reducing the number of prescriptions it issued for Cepaholsporins and Quinolones and increasing the number of prescriptions it issued for other kinds of antibiotics recommended by the CCG.

The practice used an electronic prescribing support tool to help GPs make prescribing decisions that were cost effective as well as clinically effective.

Systems were in place to ensure the practice maintained adequate stocks of medicines it used regularly to treat patients and medicines for medical emergencies. The practice reported having a very good relationship with the local pharmacy so that it could obtain additional medicines at short notice.

The practice's stock of medicines was checked regularly to ensure it was within expiry date and fit for use. Medicines were stored correctly to ensure they remained fit for use. Medicines requiring cold storage, for example vaccines, were stored in refrigerators fitted with max/min thermometers so that the temperature at which these medicines were kept could be monitored at all times. However, the refrigerators were not fitted with a second thermometer independent of mains power in case there was power cut, nor were they wired into switchless sockets to avoid them being turned off accidentally, in line with Public Health England guidance, Protocol for ordering, storing and handling vaccines. We highlighted this to the provider as an area for improvement.

Systems were in place to ensure patients received the medicines they needed in a timely way. Repeat prescriptions were issued within 48 hours and patients could order their repeat prescription in a variety of ways for convenience. The practice did not have the facility for patients to order their prescriptions online, although patients could elect to have their prescriptions sent to their local pharmacy electronically for convenience. The electronic prescription service also made the prescribing and dispensing process more efficient and the practice issued 15% of its the prescriptions in this way.

Prescription forms were kept securely to prevent them being stolen or misused. However the practice was not keeping a record of the prescription form serial numbers as an added precaution, and we highlighted this to the provider as an area for improvement.

There were safeguards in place to ensure repeat prescribing was safe. For example the practice's computer system flagged up to administrative staff when a medication review was due and the practice's repeat prescribing policy provided clear guidance to staff about what to do in this event. Prescription errors were treated as significant events to ensure appropriate action was taken to care for the patient, and the incident was investigated and learned from.

Patients on high risk medicines and those on four or more medicines were monitored appropriately to ensure their medicines continued to be the best ones for them to take.

Cleanliness & Infection Control

The practice was visibly clean and many patients commented that the practice was hygienic. The practice completed regular checks to ensure standards of cleanliness and infection control were maintained. There

Are services safe?

were appropriate facilities for hand-washing and for dealing with clinical waste. Personal protective equipment for example disposable gloves, and adequate supplies of single use items were available.

Staffing & Recruitment

The practice had recently increased its reliance on locum GPs to cover extended unforeseen leave of absence. These GPs were known to the practice and most of them worked in other local surgeries. Nevertheless, before employing them, the practice had checked these GPs were on the NHS Performers List (meaning they may provide primary medical services), their professional registration, identification, criminal records disclosure, and membership of a professional defence organisation to ensure they were appropriately qualified and suitable for the role.

We found the practice had completed pre-employment checks to ensure staff it employed were suitably qualified, skilled and experienced. It had not been the provider's policy to apply for a Disclosure and Barring Service (DBS) check before appointing non-clinical staff because of the low risk of harm the role presented to patients. The practice had not documented a formal risk assessment as part of making this policy. However, staff had signed a confidentiality agreement when they joined the practice and they had completed information governance training to ensure they handled confidential personal information appropriately.

Dealing with Emergencies

The practice's business continuity plan set out the alternative arrangements to be put in place, for example in the event of loss of utilities or incapacity of GPs, so that there would be no disruption to the service for patients.

Equipment

The practice had contracts in place for the maintenance, repair, safety testing and annual recalibration of its medical and electrical equipment to ensure it was fit for use.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients received services that were effective, although we found areas for improvement. We also found an area of good practice. People's needs were met by suitably qualified staff who worked with other services to ensure people received coordinated care. It was clear that the practice was working to recognised best practice guidelines in some areas. However the low level of clinical audit activity meant the practice was not systematically and explicitly confirming the quality of everyday care provided to patients and identifying where there was need for improvement to reach the highest possible standards.

Areas for improvement included:

- There was little formalised ongoing monitoring of outcomes for patients, including clinical audit.
- Staff appraisal was not being used to enable staff to deliver care and treatment safely and to an appropriate standard, and to engage staff in developing the service.

Our findings

Promoting Best Practice

There were areas in which the practice was following best practice guidelines. For example the practice referred patients for 24-hour ambulatory blood pressure monitoring to confirm a diagnosis of primary hypertension, in line with National Institute for Health and Care Excellence (NICE) guidelines.

However there was little in the way of formalised ongoing monitoring of outcomes for patients, including clinical audit. Clinical audit is a mechanism for reviewing the quality of everyday care provided to patients, addressing quality issues systematically and explicitly, confirming the quality of clinical services and highlighting where there was the need for improvement, then taking action to improve and checking again that improvement had been made. We highlighted clinical audit to the provider as an area for improvement.

Management, monitoring & improving outcomes for people

The practice was achieving its target for completing the NHS Health Check for its practice population. The NHS Health Check is a check of people's heart health.

The practice completed the New Patient Health Check for patients joining the practice. This ensured the practice had a record of the person's medical and family history, and that their health checks, for example cervical screening, were up to date.

We found the practice was providing effective care for patients in those other areas where the information we reviewed prior to the inspection indicated possibly poorer outcome for patients, including coronary heart disease, cancer, dementia, and mental health. The practice was improving its antibiotic prescribing and recording whether each of its patients smoked.

Staffing

GPs and the Practice Nurse employed by James O'Riordan Medical Centre were registered to practice. Arrangements were in place to support the GPs' continuing professional development, appraisal and revalidation. The arrangements included attending GPs education events at local hospitals. The practice was considering developing an in-house education programme to promote more practice-centred learning and education.

Are services effective?

(for example, treatment is effective)

The practice had taken on a new GP partner and had arranged for them to be mentored by a senior partner in another practice to provide support for them in their new role.

Administrative and reception staff were in the process of preparing for this year's appraisal which was scheduled to take place by September 2014. Some administrative and reception staff had not had an appraisal last year because the practice had prioritised the implementation of the NHS electronic medical information system for patient records. The nurse employed by the practice was also scheduled to have an appraisal this year, however they had not previously had an appraisal since 2009. We highlighted annual staff appraisal to the practice as an area where it must make improvement.

Staff felt well supported by the practice, and that the GPs and Practice Manager were approachable and listened to them. There were staff and whole practice meetings where information was shared and any problems could be rectified.

There was an informal induction process in place for locum GPs. The practice was developing a locum induction pack to ensure locum GPs were able to take up the responsibilities quickly and effectively.

Working with other services

The practice worked with other services to ensure patients received coordinated and effective care.

The district nurse and health visitor held regular clinics at the practice to improve access to these services for patients with the practice. The practice told us it was more difficult to engage with a named social worker on a regular basis because of the different provisions made by Merton and Sutton social services departments.

The practice had an electronic pathology test requesting system in place with Epsom and St Helier University Hospital NHS Trusts. The system ensured clinical information was shared securely and accurately between the practice and the hospital, and that samples were properly labelled. This reduced the number of spoiled samples. We highlighted this to the provider as an area of good practice.

The practice had a complete register available of all patients in need of palliative care and support. It shared this information with the out-of-hours service in the form of Special Patient Notes. The practice was working with the local hospice and the district nursing service to improve end-of-life care for patients. The practice reported problems with implementing the Co-ordinate my Care (CMC) electronic patient notes system. CMC is an end-of-life care service and is a way of storing information about a person's illness and any specific wishes they may have so that it is available to all services coming into contact with the patient. The practice's computer system was due to be upgraded to help with the implementation of CMC.

The practice received information in a timely way about patients who had used the out-of-hours service to ensure continuity of care.

The practice used the NHS electronic medical information system for patient records which enabled different services to share information securely and appropriately about patients. This made sure, for example, that information the GP held about the patient was available to hospital clinics and community based services. The programme also flagged information to GPs about vulnerable patients, for example children on the at risk register, to ensure they received the appropriate care they needed.

Information about some national support groups, for example Alzheimer's Society and Macmillan Cancer Support, was available for patients on the waiting room notice board. The practice's website had links to national self-help groups.

The practice told us it had some difficulties providing information to patients about local community organisations as many were borough based and patients living in Sutton could not access Merton-based services and vice-versa. However, the practice's annual patient survey in 2013 identified patients felt they should be kept informed about any activities, services and events locally that benefit health and wellbeing, and the practice had developed an action plan to meet this need.

Health Promotion & Prevention

Knowing whether a patient smokes makes it easier for the practice to help patients give up smoking. We found the practice was monitoring the recording of the smoking status of its patients and taking action to ensure the smoking status for each patient on the practice's list was recorded.

Information on a range of topics was available to patients in the waiting area. There was information about specific

Are services effective?

(for example, treatment is effective)

conditions, for example osteoporosis, diabetes and HIV/AIDS. Health promotion literature included information about healthy eating and smoking cessation services, for example. The practice's website provided links to information to help patients help themselves to stay well.

Are services caring?

Summary of findings

Patients received services that were caring. Reception staff were approachable, helpful and courteous. They took care to protect people's privacy and to keep information about them confidential and secure. A chaperone was available on request during intimate examinations. Patients could exercise choice about which hospital they went to for specialist treatment.

Our findings

Respect, Dignity, Compassion & Empathy

Reception and administration staff demonstrated a real commitment to being kind, friendly and accommodating towards patients. We observed them being approachable, helpful and courteous with patients and with one another.

Patients or members of their family we spoke with, and comment cards we received, told us staff were helpful, caring and polite.

Staff had signed a confidentiality agreement when they joined the practice and they had completed information governance training to ensure they handled confidential personal information appropriately.

There was a chaperone policy in place and staff were on hand to be present during a face-to-face consultation if the patient or GP required a chaperone. A chaperone is a third party present at a consultation that involves an intimate examination, as a safeguard for all parties and is a witness to the patient's continuing consent for the intervention. Staff had been briefed by the GP and were comfortable with the role. Information to make patients aware of the availability of a chaperone, or of a same gender health professional for intimate examinations was on display in the waiting area and in consulting rooms.

Involvement in decisions and consent

The national GP Patient Survey 2012-2013 indicated patients were involved in decisions about their care. In particular, patients said the discussions they had with their doctor or nurse helped them improve how they managed their health problem. Two hundred and sixty one surveys were sent out and 107 surveys were sent back which was a completion rate of 41%.

GPs were aware of the provisions of the Mental Capacity Act 2005 to safeguard the interests of patients who lacked capacity to make some decisions in relation to their treatment and care.

When it was agreed that a patient needed an appointment at a hospital or clinic the practice used the national electronic referral service, Choose and Book, so that patients could choose the date and time of their appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Patients received services that were responsive. Patients could get in touch with the practice easily to make an appointment to see a GP. They could book appointments early in the morning or up to one month in advance, if required. They could also book appointments with a GP of their choice, although they may have had to wait longer for these appointments.

The practice made provisions to meet the diverse needs of the population it served, and used complaints to improve the service.

Our findings

Responding to and meeting people's needs

The practice sought to meet the diverse needs of its population. The practice had its own website providing information for patients about the services it provided and how the practice worked. People using the website could select another language for this information to be translated into. The practice had use of a telephone interpreting service and could book interpreters for patient appointments. There was a hearing loop for patients with a hearing impairment and the practice was accessible to wheelchair users. There was a designated parking space and an accessible toilet for the use of patients who used a wheelchair. There was a policy in place that enabled the practice to support people with assistance dogs.

Access to the service

The national GP Patient Survey 2012-2013 indicated patients' experience of getting an appointment was very good. We found patients were usually seen within 2 to 3 days of requesting an appointment if the matter was not urgent. However this had increased recently to one week for some patients because one of the practice's GPs was on an extended leave of absence. The practice was engaging local GPs as locums to cover this GP's sessions, however some patients had been delaying their appointment in the hope of seeing the doctor of their choice. A few patients we spoke with told us they sometimes had to wait up to two weeks to see the GP of their choice, and were prepared to do this.

The practice operated extended opening hours. The practice was open from 7.30am to 6.30pm Monday to Wednesday, and from 8am to 6.30pm on Thursday and Friday.

Patients were able to book appointments up to one month in advance where appropriate to give them flexibility around fitting in seeing their GP with other commitments.

The practice did not provide online appointment booking. This reduced the number of ways in which patients could make an appointment to see a GP.

Concerns & Complaints

Information for patients about how to make a complaint was available on the practice's website. The practice

Are services responsive to people's needs?

(for example, to feedback?)

received few complaints. We saw that the practice took complaints seriously and was agreeable to learning from complaints. The practice responded to complainants in an open and timely manner.

Are services well-led?

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

Summary of findings

Patients received services that were well-led, although we found areas for improvement. The day-to-day operation of the service was well-managed.

The practice was planning to extend the scope and range of the services it provided and to establish more robust systems for monitoring and improving the quality of its services. There was as yet no overarching strategy for developing the practice in this way, although the practice had identified one of the GP partners to lead on the development of plans for the future and for succession planning.

The practice worked well with the Clinical Commissioning Group (CCG) to monitor and benchmark its performance against other practices in the area.

Areas for improvement included:

- The practice had fallen behind on its patient survey action plan to increase information for patients about activities, services and events locally that benefit health and wellbeing, and its virtual patient participation group had fallen into disuse.

Our findings

Leadership & Culture

Staff were proud to work in the practice. They believed the practice knew its regular patients very well, and that patients benefited from being seen by the same GP whom they came to know and trust. Some patients we spoke with strongly endorsed this model of care.

The practice was looking to broaden the scope and range of services it provided and to establish more robust systems for monitoring and improving the quality of its services. For example, the practice had been approved to teach medical students. This benefits the practice by extending GPs' communication skills, keeping GPs in touch with new developments, and providing a stimulus to maintain clinical standards and standards of record keeping.

The practice had identified one of the GP partners to lead on the development of the practice's plans for the future and for succession planning. These plans were at an early stage of development.

Governance Arrangements

There were staff, clinical and whole practice meetings where the operation of the practice was discussed, including incidents. There were processes in place to monitor aspects of the safety and quality of the services the practice provided, and to improve performance. However the practice had no overarching framework for driving forward improvement in a systematic way, and best practice was being developed on a responsive or ad hoc basis. For example, the practice was beginning to identify those of its patients who were carers, however there was no strategy or plan in place setting out how the practice would then go on to support carers and implement best practice this area.

Systems to monitor and improve quality & improvement

The practice worked with the Clinical Commissioning Group (CCG) to monitor and improve the quality of care it provided. The practice reflected on monitoring information provided by the CCG, for example around prescribing, and took action to improve its performance as compared with other practices in the CCG area.

The practice monitored the number and kind of referrals it made to other services, including hospitals and community

Are services well-led?

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

health services. It used this information to check patients were being referred to other services appropriately and were not having to go to hospital unnecessarily. The GPs discussed this information in clinical meetings and shared the information with the CCG to promote good practice.

Patient Experience & Involvement

While comment cards we received and patients we spoke with during our inspection were very complimentary about the practice, the national GP Patient Survey 2012-2013 indicated the wider patient population were dissatisfied with some aspects of the quality of care they received at James O'Riordan Medical Centre.

In 2013 the practice established a virtual Patient Participation Group (vPPG) to create opportunities for patients to enhance the services provided by the practice. The vPPG was involved in developing the annual patient survey that year. There were 51 respondents to the survey. Results of the survey indicated all respondents rated the practice as good or outstanding, and that they always or sometimes got to see the doctor of their choice. All respondents found the waiting area to be very comfortable or quite comfortable, and all but one found it very easy or quite easy to visit the practice. Patients were also asked what health issues they would be interested in knowing more about, and if they would like to know more about where they could go to first when dealing with a health or emergency related matter.

The results of the annual practice survey and information about the vPPG were posted on the practice's website to provide feedback to patients. The practice had fallen behind in implementing the action plan from the survey plan to increase information for patients about activities, services and events locally that benefit health and wellbeing. This was because of changing priorities in response for example to periods of extended unforeseen leave of absence due to ill health amongst its clinical staff.

The action plan on the practice's website however had not been updated and was out of date which reduced its credibility for patients, and the vPPG had fallen into disuse. Re-establishing the vPPG and taking forward the action plan were identified to the provider as an area for improvement.

Staff engagement & Involvement

Staff enjoyed working for the practice and the spirit of camaraderie. Staff were aware that the practice was changing. Some staff viewed this as something they were waiting to happen to them and not something that they were necessarily at the centre of creating.

Learning & Improvement

There was a sense that performance development plans were not relevant to some staff, for example those who had been doing their job for a long time. The practice did not recognise the benefits staff appraisal as a driver for change. For example, staff had been through a major change last year, with the introduction of the NHS electronic medical information system for patient records. The practice had not recognised that the appraisal system was the tool to use to identify staff support needs, manage performance and acknowledge success.

Identification & Management of Risk

The practice had responded to changes that increased the risk of harm to patients. For example, they had engaged locum GPs and a nurse to cover for periods of extended unforeseen leave of absence due to ill health amongst its clinical staff; the practice had made alternative arrangements for patients to obtain 24-hour ambulatory blood pressure monitoring where required when their own equipment had broken down; and they had implemented a routine check of the building at the end of the day to prevent anyone being inadvertently locked in response to an incident.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice had arrangements in place to respond to the needs of this population group.

GPs were using a recognised tool to assess patients where a diagnosis of dementia was a consideration, and patients were referred to specialist assessment services where appropriate. One of the GPs in the practice had a background in geriatric medicine and shared this expertise with colleagues. GPs visited patients at home where this was required.

Our findings

We were not able to ascertain the rate of diagnosis of dementia at James O'Riordan Medical Centre, however we found GPs were using a recognised tool to assess patients where a diagnosis of dementia was a consideration, and that patients were referred to specialist assessment services where appropriate. One of the GPs in the practice had a background in geriatric medicine and shared their expertise with colleagues.

GPs visited patients at home where this was required.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice had arrangements in place to respond to the needs of this population group.

The practice provided ongoing monitoring of these patients to keep them as well as possible and to prevent avoidable hospital admissions. For example it held disease management clinics for patients with chronic obstructive pulmonary disease (COPD), diabetes, or asthma, and carried out regular blood monitoring checks for patients reliant on drugs that had potentially serious side effects.

Our findings

The treatment of several diseases is increasingly reliant on drugs that, while clinically effective, need regular blood monitoring. This is due to potentially serious side-effects these drugs can occasionally cause. We found the practice was carrying out blood monitoring for patients, for example with arthritis, reliant on these kinds of drugs.

Information we reviewed prior to the inspection indicated the practice was monitoring and caring for patients with long term conditions effectively because the number of emergency admissions to hospital for these patients was in line with the average for London GP practices.

The practice held chronic obstructive pulmonary disease (COPD), diabetes, asthma and leg ulcer disease management clinics.

The practice was monitoring the recording of the smoking status of its patients and taking action to ensure the smoking status for each patient on the practice's list was recorded. Knowing whether a patient smokes makes it easier for the practice to help them give up smoking. This health promotion strategy is particularly important for people with long term health conditions.

Patients with long term conditions we spoke with told us they had regular appointments with their GP, for example to have their medicines reviewed or to have their blood pressure checked.

The district nurse held monthly clinics at the practice to improve people's access to this service.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice had arrangements in place to respond to the needs of this population group.

Pregnant women valued the antenatal care provided by the practice.

Children and babies were seen as a priority and on the same day on which an appointment was requested.

Best practice guidelines were in place for assessing a child's maturity to make their own decisions and to understand the implication of those decisions when giving consent to treatment.

Our findings

Pregnant women we spoke with told us they always saw the same GP for their antenatal appointments and valued their support.

A system was in place for GPs to assess how urgently children and babies needed to be seen. It was the practice's policy to see all babies and children on the on the same day. Information was available to GPs about the local acute trust's paediatric consultant advice line to help them with clinical decision making.

The practice held weekly children's immunisation clinics, and the health visitor held weekly child health clinics at the practice to improve access to these services.

A confidentiality and teenagers policy was in place providing guidance to GPs and staff about children and young people's rights to see a GP alone. The policy referred to best practice guidelines for assessing a child's maturity to make their own decisions and to understand the implications of those decisions.

The practice provided free chlamydia testing. Information was on display about places where a young person could go to for the test if they did not want their GP to test them.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice had arrangements in place to respond to the needs of this population group.

The practice provided services aimed at preventing disease. For example, the practice was completing NHS Health Checks for its target population and for new patients joining the practice. It was meeting its target for cervical screening. The practice operated extended opening hours, making it easier for working age people to get an appointment to see their GP.

Our findings

The practice was achieving its target for completing the NHS Health Check for its practice population. The NHS Health Check is aimed at adults in England aged 40 to 74. It checks a person's vascular health and works out the person's risk of developing diabetes, heart disease, kidney disease, stroke and dementia so that the practice can help the person make lifestyle changes to prevent disease. The Check also aids early diagnosis and treatment where necessary.

The practice was meeting its target for cervical screening. It offered the contraceptive injection as part of the range of contraceptive methods it provided.

The practice was beginning to identify patients who were carers as part of the information it collected when a new patient registered with the practice. This was in recognition of the increased risk of ill health and debt experienced by carers, and the part general practice can play in supporting carers to continue in their role.

The practice operated extended opening hours. The practice was open from 7.30am to 6.30pm Monday to Wednesday, and from 8am to 6.30pm on Thursday and Friday. The practice had monitored the appointments patients were trying to make and had determined these opening hours enabled it to meet the most appointment requests.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice had arrangements in place to respond to the needs of this population group.

The practice provided services responsive to people's needs based on religious grounds. It provided support for alcohol detoxification. The practice made referrals to a specialist support service for young people under the age of 20 expecting their first baby.

Our findings

The practice made referrals where appropriate to the local Family Nurse Partnership (FNP) which provides an intensive home visiting programme for young people under the age of 20 expecting their first baby. The programme works with teenagers to facilitate greater understanding of pregnancy, childbirth and sensitive response parenting.

A female GP was available to see women who expressed this preference on religious grounds.

The practice provided alcohol detoxification support.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice had arrangements in place to respond to the needs of this population group.

There were policies and procedures in place specific to meeting the needs of people experiencing poor mental health, for example around patient confidentiality.

Patients diagnosed as having depression received appropriate assessment of the severity of their depression and appropriate referral to specialist services including psychological therapy.

The practice had taken action to promote the physical health and wellbeing of its patients with a serious mental illness.

Our findings

The practice had policies and procedures in place specific to the needs of people experiencing poor mental health, for example around patient confidentiality and appropriate disclosure of patient information when a person at risk of committing suicide was missing.

The practice was monitoring patients who were reliant on certain drugs that, while clinically effective, need regular blood monitoring because of potentially serious side-effects these drugs can occasionally cause.

Information we reviewed prior to the inspection indicated that when a patient was diagnosed as having depression, the practice made an assessment of the severity of their depression. Knowing how severe the condition was at the outset of treatment allowed the GP and patient to discuss the right approach to managing their condition and options for treatment. We found the practice made referrals to specialist services as appropriate, including the Improving Access to Psychological Therapy service (IAPT).

In response to Quality and Outcomes Framework (QOF) data that people with serious mental health problems were not receiving regular reviews of their physical health and were not being offered routine health promotion and prevention advice, the practice undertook a targeted programme of work that ensured all patients with a serious mental illness had a physical health check and were offered health promotion advice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers. How the regulation was not being met: Staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, by receiving appraisal. Regulation 23 (1) (a).