Hammersmith Surgery

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Hammersmith Surgery provides primary medical services to approximately 9,400 patients in the Bridge Road area of Hammersmith in West London. This is the only location operated by this provider.

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

We rated the practice as 'Good' for the service being safe, effective, caring, responsive to people's needs and well-led. We rated the practice 'Good' for the care provided to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- There were arrangements in place to ensure patients were kept safe.
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice.
- We saw from our observations and heard from patients that they were treated with dignity and respect.
- The practice understood the needs of their patients and was responsive to them.
- The practice was well-led, had a defined leadership structure and staff felt supported in their roles.
- Pre-bookable Saturday morning appointments were available for patients who may have difficulty attending during weekday opening hours.
- The practice conducted 100% peer review of all referrals made to secondary care.

We saw an area of outstanding practice:

- Community Matron employed part time by the practice who provided support and management of patients with complex needs and the frail elderly.

Summary of findings

Since commencement of the role in July 2014 records showed that 3.7% of the practice population had a care plan in place. This was almost double the Clinical Commissioning Group (CCG) target of 2%.

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

- The practice should produce a written mission statement to be shared with members of the public.
- The practice should review the publically accessed practice information leaflets to ensure information is consistent.
- The practice should review policies to ensure the most up to date contact details of external organisations are recorded.
- The practice should consider maintaining mandatory training records for the GP's.

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?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and further training needs have been identified and planned. The practice had undertaken appraisals and personal development plans for non-clinical staff. Clinical staff maintained their own training records and personal development plans. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with NHS England and the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). Patients reported good access to the practice and with urgent appointments available the same day, although some commented negatively about the appointment system. The practice had good facilities and was well equipped to

Summary of findings

treat patients and meet their needs. There was an accessible complaints system with evidence to demonstrate that the practice responded to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

All staff had received safeguarding training and were knowledgeable in recognising the signs of potential abuse. The practice employed a part time community matron whose role included reviewing and supporting older patients at high risk of hospital admission or A & E attendance and following discharge from hospital. The practice held weekly multi-disciplinary meetings to discuss and review the care plans of older patients with complex needs. The practice provided primary care services to a local nursing and residential home caring for frail older patients and patients with dementia. The senior GP partner performed a weekly ward round at the care home and attended multi-disciplinary meetings during which care plans were reviewed.

The practice ran a well-advertised flu and shingle vaccination programme targeted to older patients in line with national guidance. All patients over the age of 75 years had a named GP and there were extended appointments and home visits available if required. The practice had access to the local 'virtual ward' scheme aimed at supporting older patients who were at high risk of hospital admission by regular review in their homes for up to six weeks. The practice was able to refer older patients to the local Older Persons Rapid Access Clinic (OPRAC) for same or next day review by a consultant geriatrician. The community matron was able to attend these appointments and advocate on behalf of patients if required.

People with long term conditions

Good

The practice is rated good for the population group of people with long term conditions.

The practice had GP leads for a variety of chronic conditions including asthma, chronic obstructive pulmonary disease (COPD) and diabetes. Both practice nurses had received appropriate training to manage and support patients with long term conditions. The practice employed a part time community matron whose role included supporting patients with long term conditions at risk of hospital admission in their homes with support from other community services. These patients could also be referred to the local 'virtual ward' scheme that provided care and support for up to six weeks form a range of health professionals and community services. The practice held a weekly multi-disciplinary team meeting to discuss and update care plans for patients with long term

Summary of findings

conditions and complex needs. Health promotion measures for patients with long term conditions included a well-advertised flu vaccination programme and referral to the expert patient programme aimed at teaching self-management of their conditions. All patients with long term conditions were invited to an annual care plan review that included reassessment of their medicines.

Families, children and young people

Good

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

All staff had received role appropriate child protection training and were aware of the processes to follow if they suspected potential abuse. There was a GP lead in safeguarding who attended quarterly local safeguarding meetings. The practice kept a register of carers including those under the age of 18. Equipment to deal with paediatric emergencies was available and maintained by the practice.

The childhood immunisation programme offered by the practice followed national guidelines and uptake rates were higher than the Clinical Commissioning Group (CCG) average. The practice offered extended hours appointments outside of school hours for families with children. The premises were suitable for children with baby change facilities and toys in the waiting area. Ante-natal services were offered including a whooping cough vaccination programme which was promoted through information literature provided to pregnant mothers.

The practice nurses were trained in family planning and contraception and there was signposting information in the waiting room to local sexual health services. Screening for cervical cancer was offered and uptake rates were higher than the CCG average.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students).

The practice operated extended hour appointments in the early mornings and late evenings for those unable to attend during weekday opening hours. Appointments were also pre-bookable for a Saturday morning. The practice website offered on-line booking for appointments for people who may be unable to telephone during opening hours to book a routine appointment. A text message reminder service for appointments was available for patients who wanted to use this. National screening programmes for cervical, breast and bowel cancer were offered.

Summary of findings

People whose circumstances may make them vulnerable

Good

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

All staff had received training in safeguarding of vulnerable adults. The practice kept a register of patients with learning disabilities and they were invited to annual 'one stop shop' health reviews that included physical checks and immunisations if required. All but one of these annual health checks had been completed and the final was due in November 2014. The premises were accessible to patients with mobility difficulties including lift access to the first floor and wheelchair access all areas of the practice. A private area was available away from the reception area for private discussions to take place with vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for people experiencing poor mental health including people with dementia.

There were processes in place for the regular review of patients prescribed anti-psychotic medication. Referrals to mental health services were reviewed weekly by the visiting mental health nurse specialist to ensure they were appropriate and directed to the service that would best meet patients' needs. The mental health nurse specialist visited twice weekly to discuss management plans and perform medication reviews for patients experiencing poor mental health. The practice nurses received ad-hoc informal training updates in mental health issues delivered by the visiting mental health nurse specialist. This included training on injection sites and warning symptoms of deterioration in a patient's mental wellbeing. Reception staff we spoke with were aware of how to recognise patients in crisis and to ensure these patients were urgently assessed by a GP.

Summary of findings

What people who use the service say

During our inspection we received 42 Care Quality Commission (CQC) comment cards that patients had completed and spoke with seven patients including one member of the patient participation group (PPG). Overall the feedback given was positive. The majority of patients were satisfied with the care they received and felt that all staff at the practice were helpful, polite and caring. This was similar to the findings of the national GP patient survey published in July 2014 which found that 86% of respondents described their overall experience of the practice as good and 83% said that they would recommend the practice to someone new to the surgery.

Nine of the 42 CQC comment cards highlighted difficulties in securing appointments and delays in the phones being answered when calling to book an appointment. Difficulty securing appointments was reflective of comments posted on NHS Choices website. We noted that nine out of the eleven comments posted since April 2014 conveyed dissatisfaction with the appointment system. The national GP patient survey 2014 showed that 63% of respondents described their experience with the appointment system as good and 80% had been able to get an appointment last time they tried. These results were less than the regional average which were 70% and 83% respectively.

Areas for improvement

Action the service SHOULD take to improve

- The practice should produce a written mission statement to be shared with members of the public.
- The practice should review the publically accessed practice information leaflets to ensure information is consistent.
- The practice should review policies to ensure the most up to date contact details of external organisations are recorded.
- The practice should consider maintaining mandatory training records for the GP's.

Outstanding practice

- Community Matron employed by the practice who provided support and management of patients with complex needs and the frail elderly. Since commencement of the role in July 2014 showed 3.7% of the practice population had a care plan in place. This was almost double the Clinical Commissioning Group (CCG) target of 2%.

Hammersmith Surgery

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, practice manager and expert by experience who were granted the same authority to enter the practice premises as the CQC inspector.

Background to Hammersmith Surgery

Hammersmith Surgery is a well-established GP practice located in Hammersmith within the London Borough of Hammersmith and Fulham and is part of the NHS Hammersmith and Fulham Clinical Commissioning Group (CCG) which is made up of 31 GP practices. The practice provides primary medical services to approximately 9,400 patients across four Clinical Commissioning Groups (CCG); NHS Hammersmith and Fulham CCG,NHS West London CCG, NHS Richmond CCG and NHS Merton CCG.

The practice holds a core General Medical Services (GMS) contract and is commissioned for the provision of local enhanced services which include extended hours, phlebotomy, post-operative wound care and International Normalised Ratio (INR) monitoring. They are also commissioned for the provision of directed enhanced services contract which includes intra-uterine contraceptive device (IUCD) fittings/check and minor surgery. The practice is responsible for the provision of medical care to residents of a local nursing home with a 96 patient capacity.

The practice team comprises of one male and two female GP partners, one male salaried GP, two female practice nurses, one part-time female community matron and six full-time receptionists. The practice also employs three female locum GPs. The practice is a training practice and hosts one trainee GP registrar. One of the practice nurses is a registered nurse prescriber.

The practice opening hours are 8.00 am to 6.30 pm Mondays and Fridays with extended hours 7.00am to 8.00pm on Tuesday, Wednesday, Thursday and 8.00am to 10.00 am on Saturdays. The out of hours services are delivered by an alternative provider. The details of the out-of-hours service are communicated in a recorded message accessed by calling the practice when it is closed and on the practice website. The practice provides a wide range of services including checks for diabetes, chronic obstructive pulmonary disease (COPD), asthma review, minor surgery, joint injections and child health care. The practice also provides health promotion services including a flu vaccination programme, twice weekly smoking cessation clinics and cervical screening.

The age range of patients is predominately 20-50 years and the number of 25-39 year olds is greater than the England average. There are a higher number of patients in paid work or full time education compared to the England average.

Why we carried out this inspection

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

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.

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

Before visiting we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We met with NHS England, NHS Hammersmith and Fulham Clinical Commissioning Group (CCG) and Healthwatch Hammersmith and Fulham and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 2nd October 2014.

During our visit we spoke with a range of staff including GPs, practice manager, practice nurses, community matron, reception manager, reception and administration staff. We also spoke with six patients who used the service and a representative from the practice patient participation group (PPG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality to patient safety. For example, safety incidents, national patient safety alerts as well as comments and complaints from patients who used the service. There were appropriate systems for managing and disseminating national patient safety alerts and guidance issued from external organisations. We saw these were an agenda item at weekly and monthly practice meetings. We reviewed incident reports from January 2014 and we were told that the practice had records for the previous four years to demonstrate that they managed safety incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. A significant event report form was completed for any incident that occurred by the staff members involved. The form included details of the significant event, the outcome and lessons learnt. We reviewed recently completed significant event reports which confirmed that outcomes, learning and changes to practice were considered and recorded. For example, a recent medication error had highlighted the importance of clear note taking at the time of a home visit or nursing home visit. Significant event reports were a standing agenda item at weekly practice meetings attended by clinical and non-clinical management staff. Outcomes were disseminated to staff verbally and minutes from the practice meetings were made available to all staff electronically. We reviewed the minutes of recent practice meetings and confirmed significant events were discussed.

Reliable safety systems and processes including safeguarding

There was a GP safeguarding lead for the practice whose role was to promote safeguarding to the practice team. The GP lead attended quarterly local safeguarding board meetings. We reviewed the safeguarding and child protection policies which were kept on a shared computer drive accessible to all staff. Staff had signed to confirm they had read and understood the documents. Safeguarding training certificates were retained in staff files. All administration staff had received Level 1 child protection training in October 2012 and all clinical staff had completed Level 3 training in January 2013. Training was updated every two years.

Safeguarding was discussed at the monthly extended team practice meeting attended by district nurses and health visitors in addition to clinical and non-clinical management staff. The electronic patient's record system highlighted if a child was listed on the child protection register. Staff we spoke with were knowledgeable in recognising potential signs of abuse, were aware of their responsibilities and understood the reporting processes if they ever suspected that abuse may have occurred.

The practice had a whistle blowing policy that documented the arrangements that should be observed by staff when seeking to disclose issues or suspicion of concerns internally or externally. However, we noted the latest whistle blowing policy recorded out of date PCT contact details. Whistleblowing was a topic included in the induction training programme delivered to newly employed practice staff.

The practice had a chaperone policy which set out guidelines for staff to follow for the protection of patients and staff from abuse or allegations of abuse. Disclosure and baring service (DBS) checks had been undertaken for staff members, including non-clinical staff who were required to chaperone patients. DBS checks had not been undertaken for two non-clinical staff members and they were excluded from chaperone duties. Staff undertook training in the procedural aspects of personal examination before they could act in the role of a chaperone.

Medicines Management

The practice had two clinical fridges where vaccinations and other types of injections were stored. Temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. Records were maintained of daily minimum, maximum and actual temperature readings. Nursing staff we spoke were aware of the process to follow if the fridge temperature breached the recommended range. There was a designated practice nurse who was responsible for ordering and safe storage of vaccinations and medicines. The practice conducted twice monthly checks of vaccine and medicine expiry dates and supplies were rotated to ensure older stock was used first.

Good

Are services safe?

Patient Group Directions (PGD) retained by the practice were correctly signed. A PGD is a specific written instruction for the supply and administration of a licensed named medicine, to specific groups of patients who may not be individually identified before presenting for treatment. PGDs should only be used by a registered nurse or midwife who has been assessed as competent and whose name is identified within each document.

There were protocols in place for the review of repeat prescribing. This included a medical review reminder at least annually but sooner if there was a change in medicine prescribed or medical need. For example, patients prescribed anti-psychotic medicines would be reviewed more frequently if there had been a change in their mental health. The medical review reminder was electronically monitored and patients who had received three reminders but had not booked a review would have the quantity of medicines prescribed reduced to prompt them to book a review appointment.

Cleanliness & Infection Control

One of the practice nurses was the infection control lead. This role included management of Clinical Commissioning Group (CCG) infection control visits and ensuring staff were up to date with required occupational health vaccinations. The practice had an infection control policy. An annual infection control audit was conducted by the CCG and any issues that arose were used to review the policy and make changes if required. We reviewed the most recent CCG infection control audit and saw the practice had met all minor actions required. For example, waiting room chairs had been changed to comply with infection control guidelines and information sheets showed to patients by the practice nurses were laminated for easy cleaning.

The practice did not conduct any formal infection control audits in between CCG annual checks. However, the infection control nurse lead told us that frequent informal infection control checks were conducted across the practice and where necessary corrective actions taken and discussed at practice meetings.

Training records confirmed the infection control lead nurse and practice contracted cleaner had completed infection control training in July 2014. All staff were up to date with required occupational Hepatitis B vaccinations.

We reviewed the cleaning specification and schedule which was provided by an external contractor. There were detailed standard operational procedures for each cleaning task. Each task was supported by a risk assessment and was fully compliant with the national cleaning specifications, including colour coded mops, buckets and cloths. There was a daily cleaning schedule for each area and an annual deep cleaning programme that incorporated curtain changes. Clinical waste including sharps were stored and disposed of correctly. A legionella risk assessment had been completed and we saw evidence that monthly water testing checks were carried out to ensure the risks associated with legionella bacteria were minimised.

Equipment

Calibration checks of medical equipment kept by the practice were performed annually by external contract arrangement. This included spirometers, thermometers, weighing scales and fridges used to store vaccinations. We saw evidence that equipment such as fire extinguishers and fire alarms were regularly checked and serviced. Fire alarms were tested weekly and fire drills conducted every three months. Portable appliance testing (PAT) of electrical equipment was completed annually with the latest check completed in September 2014.

Staffing & Recruitment

The practice followed a clinical staff recruitment checklist prior to new staff commencing employment. This included confirmation of registration with professional bodies, Disclosure and Barring Service (DBS) checks, photographic identification, two references and in the case of GPs a phone call to their previous practice employer. Staff records we reviewed confirmed the presence of these documents, although we noted one GP file did not retain two references. We were advised that a telephone reference had been taken for this GP but had inadvertently not been recorded.

DBS checks for non-clinical staff had been undertaken for two out of eight members of staff. We were told these would be completed as soon as possible and in the interim the relevant staff were not providing chaperone services to patients. All clinical staff had up to date DBS or Criminal Record Bureau (CRB) checks.

Staff told us the practice had procedures to follow in the event of staff absence to ensure smooth running of the service. This included the reception manager occasionally providing cover in reception to ensure there was never one

member of administration staff working alone during busy periods. The practice was in the process of recruiting two salaried GPs and had employed three locum doctors to provide cover in the interim.

Monitoring Safety & Responding to Risk

Processes were in place for monitoring safety and responding to risk. The practice had commissioned an external company to carry out a fire risk assessment and a health and safety risk assessment. Both risk assessments had been completed in June 2014. The practice had put in place control measures to minimise identified risks. The practice Health and Safety policy was available on the intranet for staff to refer to.

We were told that staff were able to identify and respond to changing risks to patients including deterioration in health and medical emergencies. For example, the practice nurse told us how they had recently responded to a sick patient with low blood sugar. This incident had been logged in the incident reporting book.

The practice regularly monitored and reviewed risks to individual patients and updated patient care plans accordingly. For example, there were monthly multi-disciplinary team meetings to discuss the needs of patients with complex medical conditions. The community matron employed part time by the practice was involved in reviewing and managing care plans of patients identified at high risk of a hospital admission or accident and emergency attendance. A list of patients who received end of life care was maintained so all staff were aware and the list was shared with the out-of-hours provider. A mental health nurse specialist visited the practice twice weekly to discuss and manage care plans of patients experiencing poor mental health. Staff had received training in recognising the warning symptoms of deterioration in patients' mental wellbeing.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff were up to date in basic life support training. Emergency equipment was available including an automated external defibrillator (used to attempt to start a person's heart in an emergency), access to oxygen and paediatric and adult pulse oximeters and face masks. Resuscitation equipment was kept in the nurses room and accessible to all staff. An inbuilt panic alarm system was available on the practice administration system. Emergency medicines were stored with the resuscitation equipment and included medicines for management of cardiac arrest, anaphylaxis, chest pain, seizures and hypoglycaemia (low blood sugar). All emergency medicines were in date and expiry dates were checked monthly by the practice nurse.

The practice had an emergency incident procedure which set out the action staff should take if the panic alarm system was activated and detailed the reporting procedures following an incident. Counselling services were available for staff that had been affected by an emergency incident. A business continuity plan was in place to cover major incidents or any significant disruption to services, including issues with access to the building, loss of the computer system or loss of the telephone communication system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. The GPs and nurses were familiar with current best practice guidance and had access to up-to-date guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings which logged the guidelines discussed and actions agreed. The practice had GP leads in specialist clinical areas such as care of the elderly, diabetes, asthma and chronic obstructive pulmonary disease (COPD). Clinical staff we spoke with told us they were supportive of their colleagues, for example they told us there was always a GP partner available to support them.

Data from the local Clinical Commissioning Group (CCG) showed the practices performance for antibiotic prescribing was comparable to similar local practices.

Practice data showed referrals to secondary care were in line with local area set targets for key specialities including cardiology, ear nose and throat, pain management and urology. All referrals made to secondary and other community care were subject to 100% peer review community pathway'. This meant all referrals made were reviewed by the senior partner GP to ensure that they were appropriate and directed to the correct service. Referrals rejected by the senior partner were returned to the GP referrer with explanation of why the referral was not appropriate to provide education and feedback to guide future referral practice. All referrals made to specialist mental health services, with the exception of referrals to 'Improving Access to Psychological Therapies' (IAPT), were reviewed by the visiting mental health nurse specialist to ensure they were directed to the appropriate service.

The practice employed a part time community matron whose role was to support patients with complex needs in the community. This included review of patients recently discharged from hospital who were at high risk of re-admission or accident and emergency attendance to ensure they had multi-disciplinary team care plans in place. Part of the role also included case record review of all practice patients that had attended accident and emergency or had an unscheduled admission to hospital. This information was used for learning purposes and to assess if the appropriate care plans were in place. Outcome data following commencement of the community matron role in July 2014 showed 3.7% of the practice population had received a care plan which was almost double the required CCG target figure of 2%.

We saw no evidence of discrimination when making care and treatment decisions and that the culture in the practice was that patients were referred based on clinical need only.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included an audit to review weight monitoring for patients on a weight loss medication. The initial audit in 2011 found patients taking this medication were not receiving appropriate weight monitoring and review in line with National Institute for Health and Care Excellence (NICE) guidelines. As a result the practice created a policy about prescribing this medication and educated their GPs in practice meetings regarding its use. Re-audit results in September 2014 found that patients received regular weight monitoring and practice was in line with the NICE guidelines.

A further completed audit cycle compared antiplatelet medication prescribing against recommended guidance in the treatment of patients with non-atrial fibrillation ischaemic stroke. The initial audit recommended an adjusted change to prescribing practice and the re-audit results demonstrated that prescribing adjustments had been made in line with national guidelines. Minutes from the weekly practice meeting confirmed clinical audit was a standing agenda item discussed so learning identified from audits could be disseminated to all staff.

The practice collected data for the quality and outcomes framework (QOF) and their performance was used to monitor outcomes for patients. QOF is a national performance measurement tool. The practice had met the minimum standards for QOF in asthma, high blood pressure and heart failure and the majority of the minimum standards in diabetes and chronic obstructive pulmonary disease (COPD).

The practice took part in benchmarking led by the local Clinical Commissioning Group (CCG). Benchmarking is a

Good

Are services effective?

(for example, treatment is effective)

process of evaluating performance data from the practice and comparing it to similar local practices. Data we reviewed showed the practice had comparable outcomes to other GP practices in the area.

Effective staffing

Practice staff included medical, nursing, managerial and administrative support staff. The practice was recruiting for two salaried GP posts but had employed three locum doctors for service provision in the interim. One locum doctor was employed on a three month fixed term contract and the other two locum doctors were employed as required.

We reviewed staff training records and saw that administration staff were up to date with mandatory courses. For example, basic life support (BLS) training was completed three yearly by administration staff. Clinical staff confirmed they completed BLS training annually. Two of the three permanent GPs had been revalidated and one GP was in the process of being revalidated. Revalidation is a five year detailed appraisal for GP's that must be completed in order for them to continue to practice and remain on the performers list of the General Medical Council (GMC).

All staff had received their annual appraisal in February 2014 which included a review of performance and identification of learning and development needs. Appraisals for the administration team were performed by the practice manager, for the nursing staff by the practice manager and senior GP partner and for the salaried GPs by the senior GP partner.

The practice nurses had defined duties and had undertaken training to fulfil their roles. Both nurses managed patients with long-term conditions, such as diabetes and chronic obstructive pulmonary disease (COPD) and had received appropriate training to support patients diagnosed with these conditions. One nurse had completed specialist training in prescribing and was a registered nurse prescriber. We were told that both nurses received ad-hoc training updates in mental health issues delivered by a mental health nurse specialist who visited the practice twice weekly. This included training on injection sites and how to recognise the warning symptoms of deterioration in patients' mental health.

Working with colleagues and other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to meet patients' needs and manage complex cases. Monthly multi-disciplinary meetings were held at the practice to discuss the care of patients with complex needs. These were attended by practice staff, district nurses and health visitors. There was a quarterly multi-disciplinary palliative care meeting attended by the practice clinical staff and community palliative care team to discuss the needs of patients at the end of life. The practice provided primary care services to a local residential and nursing care home. The senior GP partner performed a weekly ward round at the home and held monthly multi-disciplinary meetings to review the care plans of residents at the home. We confirmed this with the nursing home who spoke highly about the service provided by the practice.

The patient administration system received blood results electronically from the pathology laboratory at the local NHS hospital. A list of any outstanding blood results was generated and followed up by the administration staff to ensure blood results were not missed. Normal test results were reported back to patients by the receptionists and abnormal results were reviewed by the GP who would arrange any necessary follow-up actions. Discharge summaries from hospital were sent electronically; though the practice manager informed us that they were often delayed. The issue had been raised with the Clinical Care Commissioning Group (CCG).

Information Sharing

Effective processes were in place for communicating with other providers. For example, information from the practice's contracted out of hours provider was received electronically the following working day after the service had been used. If any follow up was required the information would be passed to the patient's named GP if they had one or duty doctor.

Information about patients who were receiving end of life care and where "do not attempt resuscitation" (DNAR) decisions were in place, were communicated electronically to the out of hours service and London Ambulance Service or shared via the 'Co-ordinate My Care' website if the patient had opted into this service. Staff were trained to use the electronic patient records national cervical screening programmes system. Blood and imaging results were received directly from the local hospital pathology and radiology services and there was a procedure in place to follow up on any missing results.

Good

Are services effective?

(for example, treatment is effective)

Patients were offered choice about referrals for hospital appointments but the majority of referrals were made by the GP instead of the Choose and Book system. A record of each referral including the date when sent was maintained on a spreadsheet by the administration staff so they could monitor for any delays. Urgent two week referrals for suspected cancer symptoms were faxed and a follow up phone call made after the fax was sent to ensure receipt of referral.

Any patients who required emergency assessment in hospital were given a printed summary of their medical records by the GP responsible to take to the accident and emergency department. This would be given to the ambulance crew if the patient was taken from the practice by ambulance.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 with regard to mental capacity and best interest assessments in relation to consent. Where patients lacked capacity, the practice would involve social services, family members, and carers to enable appropriate choices and decisions about their care and treatment. Practice staff had received training on the Mental Capacity Act 2005 from the visiting mental health specialist nurse, who was available to provide support and advice with regards decisions on a patient's mental capacity. We discussed mental capacity assessments conducted for residents in the local care home and we were told these were normally completed prior to admission to the nursing home with the carer's involvement.

Clinical staff we spoke with demonstrated awareness and understanding of 'Gillick competency' for gaining consent from patients under 16 years of age. Gillick competency is a term used in medical law to determine if a child under 16 years of age has the legal capacity to consent to medical examination and treatment, without the need for parental permission or knowledge. We were told that consent forms for minor procedures were printed and signed by the patient and then scanned into the electronic clinical records.

The practice kept a register of patients with learning disabilities to help ensure they received the required health checks. These patients were offered annual review appointments with their carers during which they would be supported in making decisions about their care plans. At the time of our inspection the uptake rate for the health checks was 88% and those that remained outstanding due to non-attendance had been reported to the local learning disabilities team for their assistance.

Health Promotion & Prevention

The practice had measures in place for health promotion in their patient population. New patients were offered a health check appointment within 48 hours of registering with the practice. NHS Health Checks were offered to patients aged over 40 years and above with no previously diagnosed medical conditions. However, the percentage uptake of these checks was low (0.9%).

Patients could be referred or were encouraged to self-refer to the Expert Patient Programme (EPP) which supported people who were living with a long-term condition. The aim of the program was to teach people the skills to manage their condition more effectively and help improve the quality of their life.

The practice facilitated access to the 'Kick it' stop smoking service who offered appointments on Mondays and Thursdays at the practice with a smoking cessation expert. Referrals to the service were made by the GP and patients could also self-refer. Leaflets about the service were available in the waiting area. The service offered a 12 week programme to assist people in successfully stopping smoking. The service also offered training for newly qualified GPs on smoking cessation interventions. At the time of our inspection data available showed a success rate of approximately 50% for the period from April 2014.

The practice offered a full range of immunisations for children, travel vaccines, flu vaccines and shingles vaccine in line with national guidelines. We observed prominent advertisement of the shingles vaccination for older people and flu vaccination campaigns in the practice waiting room. Data from 2013 showed uptake rates of childhood immunisations at 12 months were between 83% - 86% across the three standard vaccinations which was higher than the CCG average. These results remained similar for the 24 months and five year vaccination programme.

Cervical screening and screening for breast cancer were offered to woman in line with the national guidelines. The cervical screening uptake rate was 71% for the year 2013

Good

Are services effective?

(for example, treatment is effective)

which was above the CCG average. Women aged between 47-73 years of age are invited for breast screening as part of a three yearly recall programme. Bowel cancer screening was also promoted to people aged 60-69 years of age.

The practice offered the Human Papillomavirus (HPV) cervical cancer vaccine to girls aged 18 years who had left school and required the third dose. However, we were told the uptake was low despite the practice offering Saturday vaccination clinics and music vouchers as an incentive.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During our inspection we observed staff to be kind, caring, and compassionate towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice staff and that they were treated courteously, with kindness and respect. Many of the completed Care Quality Commission (CQC) comment cards we received referred to staff as kind, respectful, caring, polite friendly and helpful.

Evidence from the latest GP national patient survey published by NHS England July 2014 showed that patients were satisfied with how they were treated. 86% said that the last GP they saw or spoke to was good at treating them with care and concern and 68% were satisfied with the level of privacy when speaking to receptionists at the surgery which were both above the CCG average. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with doctors. 87% of respondents said that their GP was good at listening to them and 88% said their GP gave them enough time.

We saw that there was a room available if patients wanted to discuss something away from the reception area. We were told that this room was also made available for breast feeding mothers or as an isolation waiting area.

The practice had a chaperone policy and information about chaperoning was displayed in consulting rooms. Patients had the option to see a male or female GP when booking an appointment. The practice had a patient dignity policy that set standards for staff to follow in order to maintain respect and patient's dignity. These policies were available on the intranet for all staff to access.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey published by NHS England July 2014 showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 83% of respondents said the last GP they saw involved them in decisions about their care and 84% felt the GP was good at explaining treatment and results. 76% of respondents said the last nurse they saw was good at giving them enough time and 72% said the nurse was good at listening to them. These results were above average compared to the local Clinical Commissioning Group (CCG) area.

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received. They also told us the GP's explained results and treatment options well and provided sufficient information for them to make informed decisions about their care. Patient feedback on CQC comment cards we received reflected this feedback.

Patients with long term conditions were supported to manage their care. GP's could refer patients to the Expert Patient Programme, a course designed to help patients with long term conditions self-manage their condition.

Staff told us that a telephone translation service was available for patients who did not speak English as their first language and was used to involve patients in decisions about their health care and to obtain informed consent.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. CQC comment cards we received reflected this feedback. Information in the waiting room signposted patients to a number of support groups and organisations for example Action on Disability and Alzheimer's Research UK.

The practice kept a register of patients who were carers, including those under the age of 18 years. The practice computer system alerted GPs if a patient was a carer. We saw written information available in the waiting room and on the practice website for carers to raise awareness of support available to them for example, Carers UK Support Network.

Procedures were in place for staff to follow in the event of the death of one of their patients. This included informing other agencies and professionals who had been involved in the patient's care, so that any planned appointments, home visits or communication could be terminated in order to prevent any additional distress. Any patient deaths were discussed in the practice weekly team meeting so that staff were all aware when a patient had died.

The practice maintained a list of patients receiving end of life care and this was available to the out of hours provider.

Good

Are services caring?

The practice had close links with the palliative care nursing team and held quarterly meetings with them. The monthly practice extended team meeting attended by community district nurses and health visitors included a case review of all patients on the palliative care list.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of their patient population. The practice met quarterly with the local Clinical Commissioning Group (CCG) and NHS England Local Area Team to discuss local needs and plan service improvements.

The practice referred patients with complex needs at high risk of admission to a local CCG network based 'virtual ward' scheme. The 'virtual ward' was a rapid response multi-disciplinary team of clinical and professional staff from across health and social care that provided care for patients in their own homes for up to six weeks. Patients over 75 years had a named GP to co-ordinate their care. Extended appointments and home visits were available if required. The practice offered joint injections by appointment for patients diagnosed with arthritis.

The practice had access to the Older Person Rapid Access Clinic (OPRAC) at a local hospital that provided same or next-day appointments for comprehensive geriatric assessment of frail older patients. The practice employed a part time community matron whose roles included holistic care planning for the frail elderly or complex need patients who had been identified by a risk stratification tool as a potential high risk for hospital admission or re-admission. The community matron was able to refer patients to a range of multi-disciplinary health professionals if required, including physiotherapy, occupational therapy and community mental health teams. The community matron was also able to attend appointments with patients and advocate on their behalf at the patient's request.

The practice provided care to meet the healthcare needs of a local residential and nursing care home. This included patients with high nursing care need, frail elderly patients and elderly patients experiencing poor mental health such as dementia. The senior GP partner performed a weekly ward round and attended monthly multi-disciplinary team meetings to review and update patient care plans.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. All patients with long term conditions were invited for an annual review, including medication reviews, with longer time slots. Patients were encouraged to join the expert patient programme, a course designed to help patients self-manage their conditions. There were monthly multi-disciplinary team meetings to discuss the needs of patients with complex medical conditions and we were told by staff that patients were involved in creating their care plans where possible. The community matron was also involved in the review and management of care plans for patients with long term conditions.

There was a weekly baby clinic with attending health visitors for parents with babies. Children were prioritised if they required a same day emergency appointment to see a GP. The practice kept a register of carers including those less than 18 years of age who may require additional support. The practice provided ante-natal services for pregnant women and offered whooping cough vaccinations in line with national guidelines. We observed leaflets in the waiting area advertising ante-natal whooping cough vaccinations.

One of the practice nurses had been trained in family planning and contraception. Patients were signposted to local sexual health services if required and information about the services was available in the waiting room. We were told by staff that the practice was in discussions to set up a consultant-led gynaecology clinic and a consultant-led paediatric clinic at local hospitals to further meet the needs of this population group.

The practice kept a register of patients with learning difficulties. These patients were offered annual appointments with longer time slots for a 'one stop shop' health review including physical health check, immunisations, blood tests, medication review and screening where applicable. Carers were also invited to attend these appointments to advocate on behalf of the patient when appropriate. The practice had completed 15 of 16 annual reviews at the time of our visit and anticipated completing the final review by November 2014.

A mental health nurse specialist attended the practice twice weekly to discuss and manage care plans of patients experiencing poor mental health including medication reviews. All referrals for secondary and community mental health services, with the exception of referrals to Improving Access to Psychological Therapies (IAPT), were reviewed by the mental health specialist nurse to ensure that they were appropriate and directed to the correct service to meet the needs of the patient. The mental health specialist nurse also provided ad-hoc training on mental health issues to

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice staff. Patients who experienced poor mental health were kept on a register and invited for annual reviews with extended appointments. Reception staff we spoke with were aware of signs to recognise for patients in crisis and to have them urgently assessed by a GP if presented.

The practice facilitated patients' access to the local IAPT programme and sign-posted patients to various support groups and organisations including MIND. The practice monitored repeat prescribing for people who received medication for mental health needs.

The practice maintained a list of all patients who received end of life care and this was shared with the out-of hours-provider. A quarterly palliative care multi-disciplinary meeting attended by the community palliative care team was held at the practice to discuss patients and their families care and support needs.

Tackling inequity and promoting equality

We were told all staff had received equality and diversity training as part of the induction training programme in place for new staff. The induction checklist confirmed this was part of the training programme.

We were told by staff that approximately 40% of the practice population did not speak English as their first language. The practice used a telephone translation service and we were told some of the GPs and nurses spoke a second language and could also assist with translation.

The premises were accessible to patients with disabilities, for example there was street level access to the practice and lift access to the first floor. There was a hearing loop available for patients with hearing difficulties

Access to the service

The practice was open from 8.00am to 6.30pm Mondays and Fridays, 7.00am to 8.00pm Tuesday to Thursdays and from 8.00am to 10.00am on Saturdays. The telephones were manned from 8.00am to 6.30pm Mondays to Fridays and a recorded message was available at all other times. Appointments could be booked online and via smartphone app. Appointment slots were available 8.30am to 6.30pm Mondays and Fridays, 7.00am to 7.40pm Tuesdays to Thursdays and 8.00am to 10.00am on Saturdays. Telephone consultation appointments with a GP were available daily. Patients could register to receive information by text message regarding appointments and healthcare. Emergency appointments with the duty doctor were available on the same day by telephoning or on a walk-in basis. Home visit appointments for housebound patients could be requested by telephoning the surgery before 10.00am on the day. Routine appointments were pre-bookable 24 hours in advance but could also be booked up to four weeks in advance with a name GP if required. Saturday appointments could be made a week in advance.

The practice website provided information about the appointment system including how to make emergency appointments and home visits. When the practice was closed there was a recorded telephone message detailing the number patients should ring depending on the circumstance. The practice website also provided information about the out-of- hours arrangements in place.

Completed Care Quality Commission (CQC) comments cards we received showed that the majority of patients were generally pleased with the appointment system and spoke positively about the text message reminders. However nine of the 42 comment cards highlighted difficulties in securing appointments. This was similar to the majority of comments left over the last 6 months on NHS Choices website.

The practice was situated on the ground and first floor of the building. The majority of services for patients were provided on the ground floor with the minor surgery clinic room on the first floor. There was lift access available between the floors. Disabled toilet facilities were available and the waiting area was large enough to accommodate wheelchairs. There was space to park prams in the entrance area of the practice. The premises were suitable for children with baby changing facilities available and children's toys in a separate section of the waiting room.

The practice had a population of approximately 60% English speaking patients but could cater for other different languages through telephone translating services.

Listening and learning from concerns & complaints

The practice had processes in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. Information about the complaints procedure was available to patients in information leaflets held in the waiting room and on the practice website. Patients were advised to write to the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice manager with any complaints. We were told complaints were acknowledged within 24 hours and responded to within 10 working days. Complaints were responded to by written letter from the practice manager and senior GP partner.

For complaints that could not be resolved at practice level the contact details for the complaints manager at Hammersmith and Fulham Clinical Commissioning Group (CCG) and the Parliamentary and Health Service Ombudsman were detailed in the complaints information provided.

We did however, observe a discrepancy between information provided in the Complaints Procedure Leaflet and in information about complaints provided in the Access to Medical Records Leaflet. The complaints procedure leaflet stated complaints would be responded to within in 10 working days whereas the access to medical records leaflet stated they would be responded to within 21 days.

We were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all staff. We saw that complaints were a standing agenda item at the weekly practice meeting. Complaints were also reviewed annually to analyse for trends and highlight areas for improvement. We reviewed an example of a recently resolved complaint in June 2014. The complaints process had been followed but the issue could not be resolved in house and was taken to the Parliamentary and Health Service Ombudsman who did not uphold the complaint.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision and ethos to deliver good quality care to patients. Staff we spoke with were clear about the ethos of the organisation and described it as a family orientated practice which was caring, friendly and gave a good service to patients. However, there was no formal written mission statement available to members of the public. The partners provided clear leadership within the practice. Staff we spoke with told us leadership was visible and that roles and responsibilities were clear. There were lead roles for specific services for example one of the GPs was the lead for safeguarding and the senior GP partner the lead for elderly patient care.

Governance Arrangements

The practice had policies and procedures in place to govern activity. The senior GP partner and practice manager attended monthly senior management meetings with representatives from the Clinical Commissioning Group (CCG) and local practices during which governance issues were discussed. We reviewed the minutes of the most recent meeting and saw that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw QOF data that showed the practice was meeting the majority of the minimum targets for long term conditions such as asthma, chronic obstructive pulmonary disease (COPD), heart disease and diabetes. We saw minutes from weekly practice meetings that confirmed QOF data was regularly reviewed and discussed. The practice engaged with CCG led benchmarking to compare their performance with GP practices in the local area.

The practice completed a number of clinical audits to monitor performance and improve outcomes. For example, the practice had recently completed two closed loop prescribing audits into weight monitoring while on weight loss medication and anti-platelet prescription in patients with stroke. Changes made as a result of the initial audits had been demonstrated to have improved practice on subsequent re-audit.

The practice had arrangements in place for identifying, recording and managing risks. Incidents that occurred were recorded in an incident log book and significant events were discussed as a standing agenda item at weekly practice meetings. All significant events were reviewed annually to analyse for trends and make service improvements if required.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, a lead nurse in infection control and GP lead for safeguarding. Staff we spoke with we clear about their own roles and responsibilities.

Staff told us there was an open and transparent culture at the practice and that they felt supported and valued. We were told the senior management team had an open door policy and staff felt happy to raise any concerns they had with them. We reviewed minutes of weekly practice meetings and saw that issues, concerns, complaints and accolades were standing agenda items.

The practice manager was responsible for human resources policies and procedures. We reviewed a number of policies, for example recruitment checklist, induction policy and whistle blowing policy, which were in place to support staff and available to refer to on the practice intranet.

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

The practice gathered feedback from a variety of sources including national patient surveys, patient feedback questionnaires and complaints. Friends and Family Test (FFT) evaluation cards were available in reception for people to complete. FFT is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The practice had a patient participation group (PPG) that held meetings four times a year. The PPG conducted regular patient feedback questionnaires and findings had been used by the practice to implement change and make improvements to the service. Results from the PPG patient surveys were published on the practice website. For example, feedback from the PPG survey in 2013/14 had highlighted areas of weakness in the way the practice communicated to patients. As a result the practice now produced a quarterly newsletter to keep patients informed of any service changes and updates.

Are services well-led?

Good

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

The PPG was representative of various population groups; including carers, working age people and patients from different ethnic and cultural backgrounds. At the last meeting the group had noted they did not have representation from single parents with young children and set out plans to engage this group with posters in the waiting room and on the practice website. Efforts were made to encourage patients to join the group by advertising meetings in the practice waiting area and on the practice website. However, some of the patients we spoke with during our visit were not aware that there was a PPG or how to join it.

The practice gathered feedback from staff through weekly staff meetings. Staff told us they felt happy to give feedback or raise concerns at these meetings. We were told staff could report any issues when they arose to either the practice manager or senior GP partner.

The practice had a whistle blowing policy which was available for staff to access on the practice intranet. Staff we spoke with were aware of the policy and the process to follow if they had any concerns.

Management lead through learning & improvement

Records confirmed that annual appraisals were performed for all non-clinical staff and included personal development plans. We were told that annual appraisals were undertaken for clinical staff but they maintained their own personal development plans. New staff were subject to a performance review six weeks after they commenced employment and again after a further six weeks before an employment contract was issued. Staff were pro-active in identifying personal training needs. For example, one of the GPs had attended update training in minor surgery after completing an audit which showed complications with infection post minor surgery.

There were arrangements in place for the review and analysis of significant events and complaints. The processes and investigations conducted by the practice after a significant event had occurred focused upon the lessons learnt and changes required. Learning from significant events or complaints were communicated to all staff to ensure quality and improvement of service provision and patient experience.

The practice was involved in the training and development of trainee GP registrars on six monthly rotations.