Roxbourne 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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Roxborne Medical Centre on 4th February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. We found some improvements were needed to ensure they provide safe care. It was also good for providing services 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:

- Arrangements were in place to ensure patients were kept safe. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice guidance.
- 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. There was evidence of continuity of care and people were able to get urgent appointments on the same day.
- The practice was well-led, had a defined leadership structure and staff felt supported in their roles.

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

- The practice should undertake a review of health check for patients with LD and MH to increase the percentage having annual health checks and care plans.
- The practice should ensure that all learning disability patients receive a follow-up review every year.
- The practice should ensure that all staff that act as chaperones receive chaperone training.

Summary of findings

- The practice should ensure all staff receive training on infection control.
- The practice should ensure that fridge temperatures are taken daily and accurately recorded
- The practice should ensure all staff receive an appraisal
- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.
- The practice should ensure that regular fire alarm tests and fire drills are carried out.
- The practice should review their business continuity plan to ensure it gives clear instruction to staff about what actions to take in the event of an emergency and the section for relevant contact details should be completed
- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.
- The practice should ensure notes are taken for their monthly governance meetings which are attended by the partners and the practice manager.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood 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 and staff told us there were enough staff to keep people safe. A slot for significant events was on the monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually. All staff had received child protection and adult safeguarding training. An infection control audit had been carried out during the last year and improvements that had been identified were included in an action plan and completed on time.

However, some improvements were required as administration staff who were required to act as chaperones on occasions had not received chaperone training, non-clinical staff had not received training in infection control, there were gaps in the records for fridge temperatures and on occasions the temperatures taken was not accurate and fire alarm tests and fire drills had been ad-hoc. Further, staff references for two administration staff and DBS checks had not been sought before their employment started.

Are services effective?

Good

The practice is rated as good for effective. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's capacity to make decisions and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice had carried out staff appraisals and had established personal development plans for most staff. There was evidence of multidisciplinary working to discuss the needs of complex patients especially those on care plans. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Summary of findings

Are services caring?

Good

The practice is rated as good for caring. 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. Patients who had care plans received annual reviews or more frequently where needed.

We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. Patients told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. However, some patients told us they felt rushed and not listened to by one GP at the practice and had refused to see that particular GP on occasions. That GP had now left the practice. Patient feedback on the CQC patient comment cards we received was positive. GP's told us they would make phone calls to families who had suffered bereavement and offer to refer them to appropriate services for support.

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 Clinical Commissioning Group (CCG) to secure service improvements where these were identified. All vulnerable patients had a named GP. There was evidence of continuity of care and people were able to get urgent appointments on the same day. However some patients reported having difficulty getting through to the practice by phone. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders. The practice reviewed complaints on an annual basis to identify any themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon in a timely manner. The practice used a telephone translation service but the GPs spoke most of the languages used by their patient population. The premises were accessible to patients with disabilities as the surgeries were on the ground floor. Toilets were accessible to wheelchair users.

Are services well-led?

Good

The practice is rated as good for being well-led. Although there was a need for a clearly documented vision which all staff were aware of, the staff felt the vision was to give a good service, good treatment and care and to respond to concerns; however this was not documented anywhere.

Summary of findings

High standards were promoted and owned by all practice staff and teams worked together across all roles. The practice carried out proactive succession planning and had started to plan for the retirement of a senior partner. There were clear governance arrangements in place and a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients and that there was a culture of learning.

The practice gathered feedback from patients through an internal patient survey organised by their patient participation group (PPG), who met quarterly and we saw changes made as a result of feedback from this group.

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. The practice offered proactive, personalised care to meet the needs of the older people in its population and provided a range of specialist services based on their value of 'no one left alone', therefore all patients over 75 years of age had a named GP who looked after their care and treatment and they would make regular contact with patients they knew lived on their own. The named GP held regular meetings with other health care professionals to provide multidisciplinary care for older patients and liaised with appropriate health care professionals when required to ensure older patients received effective care. They also offered annual health checks to older people with no medical health concerns. They were responsive to the needs of older people and used a risk stratification tool to identify risk and plan care, whom they would visit regularly, particularly frail older patients who were vulnerable, to prevent unnecessary hospital admissions

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. They had registers for patients receiving palliative care, for those who had complex needs and/or long term conditions. There were GP leads for a variety of chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD) and asthma. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed. Patients with a long term condition had a named GP, a care plan and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to support the delivery of a multidisciplinary integrated care approach. Emergency processes were in place and referrals made for patients in this population group that had a sudden deterioration in health.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example the GPs hade monthly meetings

with the health visitor to discuss those children and families on her caseload, along with any patients who the clinicians may have concerns about and the practice regularly attended safeguarding meetings.

Data showed the under five year age group in the local area was constantly increasing, which placed high demands on their in-house baby clinic and external health visiting services. Therefore fortnightly meetings were re held with the health visitors, to ensure timely communication was maintained.

There were weekly immunisation baby clinics however, we noted that and immunisation rates were relatively low in comparison to other practices in the CCG, for some standard childhood immunisations. The GPs told us this was due to large number of transient political refugees who are temporarily housed on the nearby estate.

Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. The GPs offered family planning advice, fitted IUDs and prescribed the contraceptive pill and the Health care Assistant (HCA) provided phlebotomy services for children at that practice and from other neighbouring GP practices.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. They had extended opening one day a week and online services for ordering repeat prescriptions, booking appointments and getting test results were available. They also offered phone consultations for patients who could not attend the surgery. The practice offered an extensive range of health promotion and invited patients over 40 years of age to have an NHS health check.

People whose circumstances may make them vulnerable

Good

The practice is rated as requires good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. All vulnerable patients had a care plan that was reviewed annually. The practice carried out annual health checks for people with learning

disabilities. However, only 65% of these patients had received a follow-up review within the last year. We were told this was due to the sudden departure of their practice nurse and their inability to replace them in a timely way. The practice offered longer appointments for people with learning disabilities.

A large number of political refugees are housed on a nearby estate, with a correspondingly high demand on medical and social agencies. The estate has previously been classified as an area of high deprivation and despite a regeneration project, there remained a large element of socio-economic health problems, which could take up additional consultation time therefore longer appointments were available for patients from these groups.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Practice staff had access to an interpreter and translation service via language line to ensure that those patients whose first language was not English could access the service. The practice was accessible to disabled patients.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). All these patients had a care plan that had been reviewed annually. However, data showed only 46% of people experiencing poor mental health had received an annual physical health check in the previous 12 months. We were told this was due to the sudden departure of their practice nurse and their inability to replace them in a timely way. A nurse practitioner had recently been appointed and had created an action plan to follow up on these reviews.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The CCG employed mental health nurses who supported patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would attend the practice as necessary to meet with people recently discharged from hospital. The practice offered longer appointments for people experiencing poor mental health and provided general medical services to a large number of the residents at the a local residential mental health unit.

Summary of findings

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector local organisations including the psychology department at the local hospital for IAPT services. The GPs liaised with the local community mental health team when required and had an understanding of the Mental Capacity Act 2005. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

Staff had received training on how to care for people with mental health needs and dementia.

However, QOF data showed the practice had scored low for conditions commonly found amongst older people such as dementia. The lead GP told us this was due to GP locums who were not picking up QOF issues and/or completing appropriate paperwork. Since our inspection, the practice has now employed a nurse practitioner who will be the lead for QOF.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection and received 11 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

Most of the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. However, some patients told us they felt rushed and not listened to by one GP at the practice and had refused to see that particular GP on occasions.

Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the partner GPs gave consistently good care. The national GP patient survey found that 72% of respondents described their overall experience of the practice as good and 63% said that they would recommend the practice to someone new.

Areas for improvement

Action the service SHOULD take to improve

- The practice should undertake a review of health check for patients with LD and MH to increase the percentage having annual health checks and care plans.
- The practice should ensure that all learning disability patients receive a follow-up review every year.
- The practice should ensure that all staff that act as chaperones receive chaperone training.
- The practice should ensure all staff receive training on infection control.
- The practice should ensure that fridge temperatures are taken and accurately recorded
- The practice should ensure all staff receive an appraisal
- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.
- The practice should ensure that regular fire alarm tests and fire drills are carried out ad-hoc, the last fire alarm test was carried out in December 2014 and staff could not remember when the last fire drill had occurred.
- The practice should review their business continuity plan to ensure it gives clear instruction to staff about what actions to take in the event of an emergency and the section for relevant contact details should be completed
- The practice should develop a clear vision and strategy to deliver high quality care and promote good outcomes for patients and ensure all staff are aware of it.
- The practice should ensure notes are taken for their monthly governance meetings which are attended by the partners and the practice manager.

Roxbourne Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a practice nurse who were granted the same authority to enter the practice premises as the CQC inspectors.

Background to Roxbourne Medical Centre

Roxbourne Medical Centre provides GP primary care services to approximately 7,000 people living in South Harrow. The practice is staffed by four GPs, two male and two female who work a combination of full and part time hours. The practice employs one nurse, a HCA phlebotomist, a practice manager and seven administrative staff. The practice holds a Primary Medical Services (PMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 8am to 6.15pm Monday, Tuesday and Fridays and 8am to 12pm on Wednesday. The practice has extended opening hours on Thursdays 8am to 8pm. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provides a wide range of services including clinics for asthma, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provides health promotion services including a flu vaccination programme, travel vaccinations and cervical screening.

The 2011 Census carried out by Harrow Council reports the Roxbourne ward is Harrow's largest ward with 12,828 residents. Harrow is the third most densely populated ward. Roxbourne has the highest number of children under five years registered in the borough (1,031) with over eight percent of the resident population being aged under five. It also has the highest number and percentage of children aged 0-14 (2,915 [22.7%] of the area population) and is among the wards with the second highest number of residents aged 15-64 (8,500). Conversely, Roxbourne has the lowest percentage of population aged 65 or over (9.8%).

The practice patient population has a mixed ethnic profile; 33.95% white British, 33.68% Asian from background, 14.27% from Black/Black Caribbean and 18.11% other ethnic backgrounds.

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.

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?

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

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

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit 4th February 2015. During our visit we spoke with a range of staff (doctors, practice manager and administrative staff.) and spoke with patients who used the service. We reviewed policies and procedures, patient treatment records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff were encouraged to bring any incidents to the attention of the practice manager or one of the partners. We were told they would be immediately discussed and a course of action agreed. An incident or significant event form would then be completed and given to the practice manager. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses which were discussed at the monthly practice meetings. Meeting minutes evidenced that staff had discussed a case where a patient had received a hospital letter that was addressed to another patient. As a result the practice had implemented a double checking process for all patient letters sent out.

We reviewed safety records, incident reports and minutes of meetings from April 2014 where these were discussed. Records showed staff were appropriately reporting incidents and the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw evidence to confirm that the practice had completed a significant event analysis (SEA) annually which included identifying any learning from the incident. For example we saw a learning point from the above incident was that all staff had a responsibility to double check information being sent out with a patients personal details and confidential information.

National patient safety alerts were disseminated by the administration manager to practice staff. Staff we spoke with told us of recent alerts they had discussed regarding the Ebola virus. They told us that alerts were also discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had up to date child protection and adult safeguarding policies and procedures in place. These provided staff with information about identifying, reporting and dealing with suspected abuse. The policies were easily available to staff both in paper format and on their computers.

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on children protection. Clinicians were trained to level three and non-clinical staff were trained to level one. All staff had received safeguarding vulnerable adults training.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were contained in the policy and were easily accessible on the intranet.

The practice had a dedicated GP lead for safeguarding vulnerable adults and children and could demonstrate that they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic patient records. This included information so that staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw that where there had been a concern about a child protection issue, the practice had relied on a third party to report it to social services who failed to do so. The practice had discussed the incident at a practice meeting and a learning point was noted that it is the practices' responsibility to report these types of concerns to safeguarding regardless of any other agencies who may be involved. The safeguarding lead attended child protection case conferences and reviews where appropriate and reports were sent if practice staff were unable to attend.

Requires improvement

Are services safe?

A chaperone policy was in place copies of which were visible on the waiting room noticeboard and in consulting rooms. If nursing staff were not available to act as a chaperone administration staff had been asked to carry out this role. However, we were told that chaperone training had not been undertaken by these staff members although staff we spoke with appeared to understand their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff with chaperone duties had been DBS checked.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

Medicines were stored in two refrigerators in the conference room. One fridge was a vaccine fridge and one was a non-vaccine fridge. We discussed this with the practice on the day who provided us with evidence the day after the inspection to confirm a new medicines fridge had been purchased. There was a policy for ensuring medicines were kept at the required temperatures. However it was a PCT policy and was not specific to the practice and was out of date. Therefore there was not a clear procedure for staff to follow if temperatures were outside the recommended range and staff were not able to describe what action they would take in the event of a potential failure of the fridge.

We checked the fridge temperature records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. We found there were gaps in the fridge recordings between September 2014 and January 2015. The practice manager told us the gaps had been due to the fact that the previous practice nurse was not aware that daily monitoring of fridge temperatures was their responsibility. We saw that recordings had been taken daily for the previous two weeks before our inspection and were in range. The practice manager told us they had now taken responsibility to take the fridge temperatures on a daily basis until the new nurse started.

However we also found there were some recordings from 2014 that showed on occasions the temperature was recorded as outside the recommended range, although there were no records of what action had been taken.

Further, on the day of our inspection the non-vaccine fridge temperature showed as 19 degrees all day. Staff told us this was because the fridge had been restocked that morning, however it did not return to below nine degrees before we left. We contacted our pharmacist advisor who informed us that the practice needed to inform the PHE of the potential breach of the cold chain. The practice provided evidence after the inspection to show they had contacted both PHE and NHSE and had disposed of the relevant immunisations. PHE concluded that the cold chain had not been broken. The practice manager said they had concluded that the most likely cause was due to the position of the thermostat, however as a new medicine fridge had been purchased this would no longer be an issue.

Processes were in place to check medicines were within their expiry date. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. However, we found there were no records of stocks of medication and we saw that practice had recently had an infection control audit carried out in January 2015 which had also highlighted this. The practice manager showed us evidence that a stock audit was in progress.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The practice manager was responsible for generating repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times in locked cupboards in the practice managers office. The GPs reviewed medication for patients on an annual basis or more frequently if necessary.

GPs reviewed their prescribing practices as and when medication alerts were received. We saw that GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings which are attended on occasions by the CCG's prescribing advisor. GPs and staff we spoke with discussed the clinical meetings and how these provided them with the opportunity to keep abreast of updated medication information.

The practice did not keep controlled drugs on the premises.

Requires improvement

Are services safe?

Cleanliness and infection control

We observed the premises were mostly clean and tidy although we did find some high level dust on the cupboards in two of the surgeries. Cleaning of the premises was carried out by a contract cleaner; Mondays, Tuesdays, Thursdays and Fridays. Comprehensive cleaning records were kept which showed a list of what had been cleaned at each visit. Reception staff told us that the toilets were checked regularly throughout the day and cleaned when needed. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control however at the time of our inspection this post was vacant so the practice manager had assumed responsibility. Staff had not received training on infection control, however we saw evidence to confirm it had been booked. An infection control audit had been carried out in January 2015 by NHSE and any concerns identified had been included in an action plan which the practice was working its way through. For example, we saw that the audit had identified that all soft toys and plants should be removed from the practice and when we inspected they had been disposed of. Minutes of practice meetings showed that the findings of the audit were discussed. The practice manager was taking the lead for this in the absence of the practice nurse.

An infection control policy and supporting procedures were available for staff to refer to which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff told us they would always wear gloves to accept specimens from patients as stated in the infection control policy.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed that the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. The practice did not have arrangements in place for portable electrical equipment testing (PAT), however after the inspection the practice provided evidence to show PAT tests had been completed and an annual contract had been arranged. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors nebulisers and weighing scales.

Staffing and recruitment

The practice had a recruitment policy in place and up to date. However, we found that appropriate pre-employment checks had not been completed for all staff before they started work at the practice. We looked at a sample of recruitment files for GPs, administrative staff and nurses and found most contained proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. However, two staff references for administration staff had not been sought and DBS checks were carried out after they had started working at the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. There were procedures to follow in the event of staff absence to ensure smooth running of the service. The reception manager occasionally provided cover in reception during busy periods.

The GP partners and practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management,

staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on the intranet for all staff. The practice manager was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk action plan which was maintained by the practice manager and graded risks as low, moderate and high. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example we saw they had discussed the importance of disposing of sharps needles correctly.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health. For example the practice kept a register of vulnerable patients which provided alerts to staff to follow up on attendance and results when patients in this group were referred for tests and medical procedures. This also ensured they were able to inform GP's when patients had not attended for tests.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. An oxygen cylinder was on site and in date. The practice had an automated external defibrillator (used to attempt to restart a person's heart in an emergency) which was kept in reception. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Staff told us they had training in basic life support including cardiopulmonary resuscitation (CPR) and other emergencies such as fire and floods. Staff records showed all staff had received training which was updated every two years.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This covered areas such as fire, flood, vandalism, power failure and pandemic flu outbreak. However, we found the plan did not give clear instruction to staff about what actions to take in the event of an emergency for example the section for relevant contact details had not been completed.

A fire risk assessment had been undertaken that included actions required to maintain fire safety.

For example we saw it had identified fire alarm tests should be carried out every week and that fire drills should occur at least every year. We saw fire alarm tests and fire drills were carried out ad-hoc, the last fire alarm test was carried out in December 2014 and staff could not remember when the last fire drill had occurred. We were told the reception manager was the fire marshal and was in the process of establishing a program for both. We saw records that staff were up to date with fire training.

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 we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw the practice had monthly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example we saw 16 patients had been discussed at the last meeting where changes in their condition were noted and any additional actions were updated. Clinical concerns were also discussed at the partner's weekly meetings for cases that could not wait until the monthly meeting was held. The GPs told us staff completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

There were GP leads in specialist areas such as diabetes, cardiology, minor surgery and women's health. and ante-natal care. One GP was also the community lead for cardiology and provided a monthly report to the CCG on 24 hour ECG tapes which were performed on patients from other practices in the community clinics. These ECG tapes were sent electronically; the GP then reviewed the tapes and undertook a clinical review commenting on his findings and recommended actions, which was then relayed back to the Community Cardiology departments for actioning. The GP lead for diabetes ran a weekly clinic and had been trained to initiate insulin. The practice nurse had been trained to support people with long term conditions such as asthma and high blood pressure. Clinical staff we spoke with told us they were supportive of their colleagues and felt comfortable to ask for advice themselves.

The practice used computerised tools to identify patients with complex needs which was approximately three percent of the practice patients who, we were advised all had multidisciplinary care plans documented in their case notes,. Hospital discharge summaries were sent to the practice manager who would liaise with the relevant GP to book an appointment as appropriate, either at the surgery or the patients' home.

This involved active monitoring of their referrals to secondary care; practice data is reconciled with the hospital data and outcomes are reviewed by their peers via the monthly meeting. The aim of this initiative is to identify any inappropriate referrals and to either forward them to the appropriate agency or for example, hold the referral until all the relevant investigations are done before sending the referral on, thereby reducing resources used by the hospital to review that patient.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. Patients told us they had never experienced any discrimination at the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us five clinical audits that had been undertaken in the last year. Two of these were completed audits i.e. the practice had re-audited. The practice was able to demonstrate the resulting changes since the initial audit. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. QOF is a national performance measurement tool. For example, one GP had undertaken an audit on the effectiveness of new diabetic medications. An audit of patients who had been given the new medication found that it was not as effective at controlling blood sugar levels. Patients were therefore changed back to original medication that had been prescribed. On re-audit it was found that these patients blood sugar levels had normalised and their symptoms had reduced.

GPs told us they were committed to maintaining and improving outcomes for patients, however we noted that the QOF report from 2012-2013 showed the practice scored 843 out of 1000 and QOF information for 2013-2014 indicated the practice had not maintained this level of achievement scoring 637 out of 900, which was 21 points below the CCG average. We discussed this with the practice and were told this was due to the sudden departure of their practice nurse and their inability to replace them in a timely way. For example, diabetic reviews are carried out at the same time every year and it was during these months that

Good

Are services effective?

(for example, treatment is effective)

the practice did not have a permanent nurse. Further, some GP locums were not picking up QOF issues and/or completing appropriate paperwork. The practice has now employed a nurse practitioner who will be the lead for QOF.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as asthma and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were shown evidence to confirm that following the receipt of an alert the GPs had reviewed the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had a good understanding of best treatment for each patient's needs. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Representatives from the Finance and Prescribing team from Harrow CCG routinely attend the monthly meeting and feedback on areas where there is an increase in the trend for referrals and areas of increased spend for prescribing. This benchmarking data showed the practice had outcomes that were similar to other services in the area.

Effective staffing

The practice staff team included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the doctors. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

The staff induction programme covered a range of topics such as health and safety, basic lifesaving, child protection and fire safety. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. Staff also had access to additional training to ensure they had the knowledge and skills required to carry out their roles. For example, reception staff told us they had received information technology training, in relation to the patient's database and customer service.

Non–clinical staff told us they had regular opportunities to hold discussions about their work during the week, as the practice manager operated an 'open door' policy. Clinical staff received monthly clinical supervision. All staff received annual appraisals which identified learning needs. Non-clinical staff were appraised by the practice manager and clinical staff were appraised by one of the partners. Staff records demonstrated that most appraisals were up to date, however some reception staff had not been appraised in the last 12 months. We saw performance and personal development were discussed at these reviews. There were arrangements in place to support clinical staff through the revalidation process. For example the salaried GPs were supported to attend study days in regards to any updates in key aspects of their role such as dementia training.

Administrative staff we spoke with confirmed that the practice was proactive in providing training and funding for development courses. For example, two receptionists had been trained as phlebotomists.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results, letters from out of hour's providers, the NHS 111 advice service and local hospital including discharge summaries were received electronically. All relevant staff were aware of their responsibility for passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The practice manager circulated the documents and results to the relevant GPs who were responsible to carry out the action required. All staff we spoke with understood their

Good

Are services effective?

(for example, treatment is effective)

roles and felt the system in place worked well. We were told here were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held bi-monthly multidisciplinary team meetings to discuss the needs of complex patients e.g. those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. The GPs told us that they would often have ad hoc discussions outside of these meetings when they had serious concerns about patients.

Information sharing

Effective processes were in place for communicating with other providers. For example, information was received electronically and by post from out-of-hour and secondary care services. We were told the practice received 90% of hospital discharge letters electronically and the remainder by post. They were directed to the appropriate GP to be actioned if required. An electronic system was also in place for making referrals for tests or to see specialists. The practice did not regularly use the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) as staff told us they encountered a number of difficulties with this system and found it easier to arrange hospital appointments manually via the phone, fax or emails. A record of each referral including the sent date was maintained on a spreadsheet by the administration staff to 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.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The out of hours providers connected to the same electronic patient record as that of the practice.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in relation to assessing a person's capacity to give consent. Clinical staff had received training on the Mental Capacity Act 2005. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, one GP told us about an older person with Dementia and that a capacity assessment had been carried out in relation to 'end of life' care arrangements.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The practice kept a register of these patients 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.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this.

Health promotion and prevention

All new patients who registered with the practice were offered a health check with the practice nurse within a week of registering. The GP was informed of all health concerns detected and these were followed-up in a timely manner. GPs told us they would use their contact with patient's to help maintain or improve mental, physical health and wellbeing. For example they would take a patients' blood pressure and on occasions had offered opportunistic diet and nutrition advice.

The practice also offered NHS Health Checks to all patients aged 40-75 without a known chronic condition. Practice data showed that less than 50% of patients in this age group took up the offer of the health check. The practice manager said they did not actively chase up the ones that did not attend, but would opportunistically discuss the check when patients attended the surgery for routine appointments.

Good

Are services effective?

(for example, treatment is effective)

The health care assistant had been trained to give advice on smoking cessation and did not run a specific clinic, but gave advice opportunistically when called upon to do so by the GPs.

Screening for breast, bowel and cervical cancer was offered in line with national standards. The practice performance for cervical smear uptake was 61% for 2013 - 2014 which was below other practices in the local CCG area. We were told this was also due to the length of time it took them to replace the practice nurse. The nurse practitioner was now responsible for following up patients who did not attend screening.

The practice offered screening for Chronic Obstructive Pulmonary Disease (COPD) in patients aged 35 years and over who were current or ex-smokers. These patients were offered a lung function test appointment and abnormal results were discussed with the patient's GP. This service was advertised with an information leaflet in the waiting room.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations at age 12 months was approximately 50% which was lower than the average for the CCG area. The GP told us this was also due to the sudden loss of the practice nurse and that they had already seen an improvement in these figures since the nurse practitioner was employed.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and a survey of patients undertaken by the practice's Patient Participation Group. (A selection of patients and practice staff who meet at regular intervals to decide ways of making a positive contribution to the services and facilities offered by the practice to the patients.) The evidence from both these sources showed patients were satisfied with their experience at the practice. For example in their own patient survey 80% patients said they were satisfied with the practice. In the national patient survey 72% describe their overall experience as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses, with 75% of practice respondents saying the GP was good at listening to them and 79% saying the GP gave them enough time as compared to 69% and 70% respectively for the CCG.

We spoke with 9 patients and most said they were treated with respect, dignity and compassion by all the practice staff. However, some patients told us they felt rushed and not listened to by one GP at the practice and had refused to see that particular GP on occasions. When we spoke with the registered manager about this they told us patients had complained directly to the practice also about this GP, but the GP was no longer employed there. Patients said the care was good and staff were friendly, professional and accommodating. Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients felt the practice offered a good service and staff were helpful and caring. They said staff treated them with dignity and respect.

We observed staff to be caring and compassionate towards patients attending the practice and when speaking to them on the telephone. Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us that they had never witnessed any instances of discriminatory behaviour or where patients' privacy and dignity had not been respected. They said there were some patients whose circumstances made them vulnerable such homeless people or people experiencing poor mental health, who often came to the surgery, but the practice was clear about its zero tolerance for discrimination and made it clear to all patients. The lead GP told us they would investigate all such incidents and any learning identified would be shared with staff and patients. We saw staff received training in diversity and patient involvement.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in this area. For example, data from the national GP patient survey from July 2014 showed 75% of practice respondents said the GP involved them in care decisions and 74% felt the GP was good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received with most GPs. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. However, it was very rarely used as the GP's spoke the same languages as the majority of their patients.

The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection were positive about the emotional support provided by

Good

Are services caring?

staff at the practice and this was reflected in the patient survey information we reviewed and the comment cards we received. For example, patients described how staff responded compassionately when they had been diagnosed with certain conditions.

Notices in the patient waiting room and information on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete carer's forms where appropriate and there were written information available for carers to ensure they understood the various avenues of support available to them.

There was a robust system of support for bereaved patients both provided by the GP's and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. People were given the option to be referred for bereavement counselling or signposted to a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider. The practice worked closely with the palliative care nursing team and held quarterly meetings with them. Deaths of patients were discussed at the monthly practice team meetings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example a large number of political refugees are housed on a nearby estate, with a correspondingly high demand on medical and social agencies. The estate has previously been classified as an area of high deprivation and despite a regeneration project, there remains a large element of socio-economic health problems, which can take up additional consultation time therefore longer appointments are available for patients from this population group. We were told that the under five year age patient group was continually increasing, which placed high demands on their in-house baby clinic and external health visiting services. As a response the practice held fortnightly meetings with health visitors, which facilitated good communication between the two agencies.

The practice also provided general medical services to a large number of the residents at the Roxbourne Complex (a residential mental health unit), with a correspondingly high demand on their medical services.

The practice used a risk profiling tool which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The GPs attended multi-disciplinary group meetings every two months with external professionals to discuss the care of patients including those at risk of unplanned admissions and A&E attendances.

The practice had clinical leads for a variety of long term conditions including diabetes, asthma, cardiology and gynaecology. Patients over 75 years had a named GP to co-ordinate their care. The practice had a list of older people who were housebound whom they would visit regularly particularly frail older patients. Further, the HCA provided phlebotomy services for children at the practice and from other neighbouring GP practices.

We reviewed a sample of patient care records and found that people with long term conditions, learning disabilities, dementia and mental health disorders received regular medicines and care plan reviews as required alongside annual care reviews. .

One GP attended monthly multi-disciplinary team meetings to review and update these patients care plans. 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 they presented at the practice. All staff had attended dementia awareness training.

The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed.

The practice had a TLC (tender loving care) list which was updated monthly with patients discussed at that practice meeting. Any patient with a new condition, for example a new cancer diagnosis was discussed prior to being added to the TLC list. Any patients who were deemed vulnerable were also brought to the meeting by the relevant clinician and discussed. Patients who had passed away during the previous month were also discussed to see if there were any learning points from their illness and also to identify any family members who may need extra support or kindness.

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). For example, they had changed the appointment system to make more daily appointments available

Tackling inequity and promoting equality

We were told by staff that a high proportion of the practice population did not speak English as their first language, however the GP's spoke most of the languages spoken by the patients. The staff also had access to language line.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The premises were accessible to patients with disabilities and the toilets were accessible to wheelchair users. The corridors were wide enough to accommodate mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Staff attend equality and diversity training as part of their mandatory training. Staff we spoke with confirmed that they had had discussions in practice meetings about equality and diversity issues and that it was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 8am to 6.15pm Monday, Tuesday and Fridays and 8am to 12pm on Wednesday. The practice had extended opening hours on Thursdays until 8pm and was particularly useful to patients with work commitments. The telephones were manned daily whilst the practice was open and a recorded message was available at all other times. Appointment slots were available throughout the opening hours. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments on the practice website which allowed patients to book appointments and home visits, order repeat prescriptions and access test results. Information was displayed in the practice waiting room and on the website directing patients to the NHS 111 out of hour's service when the practice was closed. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of hour's service was also provided to patients in the practice information leaflet.

Patients were generally satisfied with the appointments system. However, some patients we spoke with in the practice said it was always difficult to get through on the phone and often when you did there were no appointments available. The practice manager told us they were reviewing the telephone system and would be employing another salaried GP. Comments received from patients and on the CQC comment cards showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. All patients we spoke with told us they had always been able to get an emergency appointment and if they had not been able to see the doctor the same day, they said they were able to talk with them on the phone.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice's complaints policy and procedure were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and in the practice information leaflet was available and given to patients when they registered. There was also information about how to contact other organisations such as NHS England to make a complaint displayed on the walls. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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

The practice kept a complaints log and we were told by staff that complaints were regularly discussed and any learning or changes to practice disseminated to all staff.

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 did not have a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The lead GP said the vision was to give a good service, good treatment and care and to respond to concerns; however this was not documented anywhere. Further we noted there was a practice charter displayed on the website which only expressed 'the rights and responsibilities of the patient'. Staff we spoke with were vague about their understanding of the vision and values but were clear about their responsibilities in relation to providing good care at the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff we spoke with confirmed they had read the key policies such as safeguarding, health and safety and infection control. All seven policies and procedures we looked at had been reviewed annually and were up to date.

We were told the practice held monthly governance meetings which were attended by the partners and the practice manager. They said they discussed performance, quality and risks. However they were no minutes available for us to confirm this.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance, however we noted that the QOF report from 2012-2013 showed the practice scored 843 out of 1000 and QOF information for 2013-2014 indicated the practice had not maintained this level of achievement scoring 637 out of 900, which was 21 points below the CCG average. The practice were clear about the reasons for this and had appointed a nurse practitioner and a salaried GP with experience of leading on QOF. There was a clinical lead for the different areas of the QOF and we saw an action plan had been produced to maintain or improve outcomes. We saw QOF data was now regularly reviewed and discussed at the practices monthly meetings.

The practice took part in a peer reviewing system with neighbouring GP practice from the South Harrow area. We looked at notes and saw that they met quarterly and discussed topics such as collaboration, referral pathways and specialist services such as phlebotomy. It was also an opportunity for practices to work together to develop services focused on the needs of the local population for example nursing homes and residential care.

The practice had completed a number of clinical audit cycles, for example we saw they had carried out an audit to compare the effectiveness of a new diabetic drug in controlling diabetic sugar levels. The re-audit found that the new drug was not as effective at controlling blood sugar levels. Patients were therefore changed back to original medication.

The practice had robust arrangements in place for identifying, recording and managing risks. Identified risks were included on a risk matrix maintained by the practice manager which graded risks as low, moderate and high. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk. We saw that the risks were regularly discussed at team meetings and updated in a timely way.

Leadership, openness and transparency

There were named members of staff in lead roles for example the partner GPs were the leads for safeguarding and infection control. All members of staff we spoke with were clear about their own roles and responsibilities and knew who the leads for all areas were. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They felt they worked well together and that they were aware of their areas of weakness such as the need to improve their cervical screening take up. Staff said the leadership team were always open to suggestions.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, For example, the recruitment and qualification checking procedure which was up to date. We were shown the staff handbook which was available to all staff.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active patient participation group (PPG) which met quarterly. Information about the PPG was

Are services well-led?

Good

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

available on the practice website. The PPG included representatives from various population groups including, older people, carers and patients from different ethnic and cultural backgrounds. However, the practice recognised that the group was not representative of the practices patients or example there were no young people, and had tried a number of ways to increase the membership. Meetings were held quarterly and one GP and the practice manager attended. We were shown minutes of meetings held in 2014 and saw that they had discussed review of terms of reference of the patient group, introduction of new virtual patient forum and the patient survey. We were told minutes were distributed to members and displayed on notice boards at the practice and placed on their website.

The practice had gathered feedback from patients through PPG patient surveys, comment cards and complaints received. We looked at the results of the in-house annual patient survey from 2014 and saw that one area reviewed was the telephone system. A new telephone system was installed in March/April 2013 which had streamlined the way in which the telephone was answered, with increased ability to speak to individual members of the practice team. The results showed access on the telephone had improved but some patients were still unhappy with the wait at busy times. We saw that as a result the practice had decided to ensure that there were adequate numbers of staff to answer the phones at busy times and continue to audit wait times using the new software.

Staff told us they could give feedback and discuss any concerns or issues with colleagues and management. They also told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. Staff we spoke with were aware of the policy and the process to follow if they had any concerns

Management lead through learning and improvement

The practice had a clear understanding of the need to ensure staff had access to learning and improvement opportunities. Newly employed staff had a period of induction to support them. We looked at staff files and saw that most annual appraisals were up to date. Appraisals included a personal development plan and staff told us that the practice was very supportive of training.

The practice scheduled meetings for the whole staff team, clinical and non-clinical. We saw from the minutes of meetings that they discussed where improvements to the service could be made.

The practice had completed reviews of significant events and other incidents and shared learning with staff via meetings to ensure the practice improved outcomes for patients. For example following an incident where the practice had failed to process a referral was to the hospital as referral was not written at the time so it was not processed. As a result all doctors reviewed their processes for passing referrals to the secretary and now send an electronic task to the secretary plus print off a letter as a failsafe.