Dr Jonathan Fluxman

Quality Report

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

Summary of findings

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Overall summary

Harrow Road Health Centre is a general medical practice providing the regulated activities: diagnostics and screening procedures; maternity and midwifery; treatment of disease disorder or injury and surgical procedures to approximately 4500 patients in the North East part of the London Borough of Westminster.

We carried out an announced inspection of the service on the 21 May 2014. During our inspection we spoke with a range of staff including GPs, nurses, and management and reception staff. We also spoke with patients and a representative from the practice's patient reference group (PRG).

The premises were suitable and appropriate health and safety checks had been completed. There was a recruitment policy in place and staff had received up-to-date training appropriate to their role. There were clear procedures for safe guarding children and vulnerable adults from harm. Staff were trained in dealing with medical emergencies and appropriate emergency equipment was available, although not all rooms were equipped with an emergency alarm pull cord. Medicines and vaccinations were in-date and stored safely.

There were regular clinical meetings and audits to promote and maintain best practice. Staff received appropriate induction and attended regular appraisal to identify training needs. The practice worked collaboratively with other allied health professionals to provide integrated care pathways for their patients. There was a pro-active approach to health promotion and prevention.

Staff were observed to be courteous and approachable when dealing with patients. Consultation rooms were equipped to maintain privacy and dignity. Patients felt they received compassionate care and were supported to be involved in decisions about their care and treatment.

The practice provided a wide range of services and clinics to support the varied needs of their patient population. They provided email and telephone access for patients to contact their usual GP and same day emergency appointments were also available. There was an effective complaints procedure for patients to raise concerns about the service.

There was a clear strategy for the practice and leadership was visible and supportive. The practice engaged in regular clinical audit and performance checks to ensure the service they provided was monitored and improved to deliver high quality care. Patient feedback about the service was gained from the patient reference group (PRG) established at the practice and from local annual patient surveys. Staff feedback was encouraged in regular team practice meetings. There were systems in place to record and learn from any significant incidents and complaints.

The practice provided and had access to a range of services to support the needs of the different patient population groups attending the practice. These included rapid referral to secondary care for frail elderly patients, health visitor clinics for babies and young children and on site access to staff with skills in supporting people with drug misuse problems and people experiencing poor mental health. The practice operated an open access for all policy so that vulnerable people could receive accessible health care without negative attitudes.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The premises were suitable and appropriate health and safety assessments had been completed. There was a system in place to record and learn from significant incidents. Staff had received appropriate safeguarding training and understood the process to follow if they suspected a vulnerable patient was at risk of harm.

There was an identified lead for infection control and staff had received training in infection control and prevention. The premises were generally clean and tidy and clinical rooms were uncluttered, though some high level storage shelves and window ledges were found to be dirty. Medicines kept on-site were in date and stored in a locked cupboard. Vaccinations and other injections were stored in refrigerated conditions that were monitored effectively.

There was an up to date recruitment policy, which reflected safe and effective practices when recruiting staff. Staff were trained in dealing with medical emergencies and had access to emergency equipment and medicines that were regularly checked.

Are services effective?

The practice had measures in place to promote best practice. There were regular mandatory clinical meetings for discussion of educational topics and guidelines to ensure clinical staff remained up to date with current evidenced based medicine.

The practice attended NHS West London Clinical Commissioning Group (CCG) led clinical learning set meetings that reviewed data from other practices in the area and allowed comparison of outcomes and benchmarking. This meant the practice could compare their performance with other practices and use this to drive improvement.

All staff had appropriate induction training and engaged in regular appraisal. This allowed for review of performance to identify areas for improvement and plan training accordingly.

The practice engaged with other local allied professionals to ensure the best integrated care was delivered to their patients. There were monthly multi-disciplinary team meetings with a range of health and social care professionals to discuss and plan care for high need patients.

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The practice had a pro-active approach to health promotion by inviting patients to NHS health checks, providing a surgery pod for patients to check their own blood pressure and weight and by running a variety of health promotion clinics including smoking cessation.

Are services caring?

Staff were observed being courteous and approachable and patients felt they were treated with respect.

Consultations took place in appropriate rooms that maintained patient's privacy and dignity and there was ready access to chaperone service for examinations if required. Patients felt they received compassionate care and were treated with dignity.

The practice took measures to ensure patients were involved in decisions about their care. There was a range of information leaflets for patients on health topics to support decision making and these were available in different languages. Patients felt they were involved and supported to make decisions about their care.

Are services responsive to people's needs?

The practice had measures in place to respond to and meet the needs of their patient population. The practice ran clinics for specific population groups including families with young children, people with learning difficulties and their carers and clinics for chronic disease management. They had clear pathways and access to dedicated services to support vulnerable population groups including people with drug misuse problems and the frail elderly.

The practice had an open access policy for all and each patient had a named GP. The 'Talk to your GP' system allowed patients to ring up and arrange for a call back from their usual GP on the same day for medical advice. Appointments could be requested online for non-urgent issues via the 'email your GP' facility on the practice website. Emergency issues were dealt with by same day urgent appointments or home visits.

The practice had a clear policy and procedure for complaints and patient feedback was encouraged. Complaints were reviewed at the weekly GP meetings and any learning points were disseminated to all staff.

Are services well-led?

There was a clear vision and strategy for the practice that all staff were aware of and understood. There was strong and visible leadership from the GP partner and practice management. The practice had governance arrangements in place including a range of internal checks and audits to monitor performance. There were

Summary of findings

regular management meetings to discuss organisation issues of the practice. There were systems in place for monitoring quality and improvement including internal peer review of secondary care referrals to ensure patients received the best and appropriate care to meet their needs.

The practice ran a patient reference group (PRG) to gather feedback from their patient population and ensure they were involved in decisions about the range and quality of services provided. They also received feedback from the annual patient survey conducted locally by the practice and from national feedback surveys. Staff at the practice felt generally well supported and listened to. They had the opportunity to engage with management and provide feedback at team practice meetings.

There was a culture of learning from complaints and significant incidents at the practice. Complaints reports and significant event analysis reports were produced detailing learning points and action plans put in place to improve the service.

The practice had measures in place to anticipate and manage risk including procedures to cope with any significant disruption to service.

Summary of findings

The six population groups and what we found

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

Older people

The practice had measures in place to support the needs of older patients in their practice population. All patients over the age of 75 years had a named GP.

They had access to a wide range of services including older person's rapid access clinic (OPRAC) with same or next day assessment for frail elderly patients by secondary care and access to memory service assessments.

The practice had access to a Primary Care Navigator (PCN) who could support older patients in accessing health, social care and voluntary sector services in the community.

People with long-term conditions

The practice had measures in place to support and meet the needs of people with long-term conditions in their practice population.

Patients with a chronic condition had a named GP as a clear point of contact for the management of their medical needs. The practice held monthly multi-disciplinary team meetings with a range of allied health professionals to plan integrated care pathways for patients with chronic and complex needs. A rolling programme of call and recall was maintained for influenza vaccination uptake.

Mothers, babies, children and young people

The practice had measures in place to support and meet the needs of mothers, babies, children and young people.

The practice ran a weekly child health and immunisation clinic provided jointly by a GP, practice nurse and health visitor to support the needs of families with babies and young children. A monthly specialist child health clinic with a paediatric consultant was also held, which other local practices could refer to. There was a child and baby emergency walk in service daily to ensure access to urgent care if required.

The practice ran health promotion clinics for mothers and young people including family planning, ante-natal and post-natal care and smear testing.

The working-age population and those recently retired

The practice head measures in place to support and meet the needs of working age people in their practice population.

Summary of findings

The practice had a range of methods for patients to contact their usual GP without attending the practice, including email and telephone advice, to ensure health care was accessible to patients of working age. There were no face-to-face GP appointments for patients to access outside of normal working day time hours.

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

The practice had measures in place to support and meet the needs of people in vulnerable circumstances.

The practice had a long standing open access arrangement to treat people in vulnerable circumstances and ensure they did not encounter any negative attitudes.

The practice ran specific clinics to support patients in vulnerable circumstances including joint clinics for patients with learning difficulties and their primary carer. The practice had integrated extended on site services to support the needs of people with drug misuse problems.

People experiencing poor mental health

The practice had measures in place to support and meet the needs of people experiencing poor mental health in their practice population.

The practice had on-site access to a community psychiatric nurse and an on-site counselling service was available. The practice maintained a rolling programme of cervical screening call and recall for female patients in this population group.

Summary of findings

What people who use the service say

Patients we spoke with told us staff at the practice were respectful and polite. They felt they received compassionate care and were treated with dignity. Patients also told us they felt involved and supported in making decisions about their care.

However, some patients we spoke with and the two Care Quality Commission (CQC) comment cards that were returned, told us they were not happy with the GP telephone consultation appointment system. They told us they thought the call back system was not efficient and that if the call back from the GP was missed the process had to be started again.

Areas for improvement

Action the service COULD take to improve

- Confirm that the practice GPs receive infection control training and if they had not had training in the last 12 months to consider completing training.
- Review the location of the surgery pod system to ensure there is a pull cord alarm available for patients to signal for help in the event of an emergency.
- Review the practical assistance and support for visually impaired patients.
- Provide clinical supervision/support for nursing staff.
- Review the monitoring process of failed GP telephone call back contact that is pre-arranged with patients.
- Increase patient awareness on how to convert telephone consultation into face-to-face consultation if patients wished.

Good practice

Our inspection team highlighted the following areas of good practice:

- Good links with external organisations to enable vulnerable people, including sex workers and homeless people to access the service.
- Primary care navigator available to assist patients aged 55 years and over and their carers in accessing health, social care and voluntary sector services in the community.
- Integrated extended on-site services including access to staff with skills in supporting people with drug misuse problems and people experiencing poor mental health.
- Surgery pod that enabled patients to measure their own vital signs for example, blood pressure and pulse rate, linked to the electronic patient record system.
- On-site monthly child health clinic with paediatric consultant in attendance which other local practices could refer to.
- Specialist email service that allowed the practice GPs to email local hospital consultants from a variety of clinical disciplines for advice.

Dr Jonathan Fluxman

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The lead CQC inspector was accompanied by two specialist advisors; a GP, a Healthcare Manager and an expert by experience. They were all granted the same authority to enter Harrow Road Health Centre as the CQC inspectors.

Background to Dr Jonathan Fluxman

Harrow Road Health Centre is a GP practice situated within the geographical area of NHS West London Clinical Commissioning Group (CCG). The practice is located in West London in the North East part of the London Borough of Westminster. The Paddington and Westbourne Green area has a cosmopolitan population and has a number of distinct characteristics that are reflected in the practice population profile:

As of February 2014, approximately 4,500 patients were registered at the practice, of these 24 percent of patients are aged 0-16, 52 percent aged 25-54 and 2.5 percent aged over 75 years.

The practice team included one male GP partner, three salaried female GPs, two non-prescribing practice nurses, a practice manager, assistant practice manager, reception and administrative staff. A further non-practicing GP provided support for clinical organisation. The practice opened Monday to Friday from 09:00–13:00 and from 14:00–18:00, with the exception of Thursday afternoon when the practice was closed.

The practice operated from converted premises spread over three floors, with nine consultation rooms. Access to the building was suitable for people who used a wheelchair and a lift was available to access upper floor consultation rooms. A children's play area was located on the ground floor reception area, baby changing facilities and a parent and baby room was available for use.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before our inspection, we reviewed a range of information we hold about the practice from our Intelligent Monitoring System. We met with NHS England, NHS West London Clinical Commissioning Group (CCG) and Healthwatch Central West London and reviewed the information they gave to us. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 21 May 2014.

During our inspection, we spoke with a range of staff including GPs, nurses, and management and reception staff. We also spoke with patients and a representative from the practice's patient reference group (PRG). We looked around the building, checked storage of records, medicines and cleaning materials. We checked records of health and safety checks, infection control audits, clinical audits, significant incidents, 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 comment cards completed by patients who attended the surgery on the day of our visit.

Are services safe?

Summary of findings

The premises were suitable and appropriate health and safety assessments had been completed. There was a system in place to record and learn from significant incidents. Staff had received appropriate safeguarding training and understood the process to follow if they suspected a vulnerable patient was at risk of harm.

There was an identified lead for infection control and staff had received training in infection control and prevention. The premises were generally clean and tidy and clinical rooms were uncluttered, though some high level storage shelves and window ledges were found to be dirty. Medicines kept on-site were in date and stored in a locked cupboard. Vaccinations and other injections were stored in refrigerated conditions that were monitored effectively.

There was an up to date recruitment policy, which reflected safe and effective practices when recruiting staff. Staff were trained in dealing with medical emergencies and had access to emergency equipment and medicines that were regularly checked.

Our findings

Safe Patient Care

The practice had systems in place to ensure safe patient care. Staff received appropriate induction and training applicable for their roles, including infection control, cardio-pulmonary resuscitation and safeguarding people from harm. Clinical staff held lead roles in specific aspects of the service and were responsible for sharing any learning or updates to clinical practice with the clinical team. These roles included GP leads for a range of long term conditions that the patient population experienced as well as medicine prescribing, women's health and a nurse lead in infection prevention and control.

Learning and clinical updates were a standing agenda item of the weekly GP meeting and monthly clinical team meetings held at the practice. We were told that clinical staff shared learning from seminars and study days at these meetings. The GP partner attended a monthly NHS West London Clinical Commissioning Group (CCG) network learning forum, from which knowledge gained was shared with the practice clinical team.

The practice had procedures in place for the reporting of any compromises to the safety of patients and staff. Staff were aware of the processes to follow. There was evidence that adverse safety incidents were investigated and outcomes shared with staff. We were told that communication alerts were raised with staff to inform of any actions or changes to processes that required immediate attention.

Learning from Incidents

The practice had processes in place to ensure significant incidents were reported, investigated and learnt from. We saw evidence of twice yearly significant events analysis meetings during which significant incidents that had occurred in the previous six months were discussed. We reviewed the significant event analysis report for 2013/2014, which detailed the incidents that had occurred during the period, the learning outcomes and actions for each one. We saw for example, an incident had occurred when a referral had been made to the wrong team and as a result, a learning discussion was held with the clinical team to inform staff of the appropriate referral process.

Are services safe?

Completed significant event analysis reports were distributed to all staff to ensure that learning points were disseminated throughout the practice.

Safeguarding

The practice had safeguarding policies and procedures in place to guide staff about their role in protecting children and vulnerable adults from harm. Training records demonstrated that clinical staff and non-clinical staff had completed the appropriate level of safeguarding training for the protection of children and had received training in protecting vulnerable adults from harm. Staff we spoke with demonstrated understanding and knowledge in recognising potential signs of abuse and described the processes they would follow to report any concerns if they suspected a patient was at risk of harm. Safeguarding information alerts were built into the patient administration system. A GP safeguarding lead was responsible for quarterly child protection register reviews.

Monitoring Safety & Responding to Risk

The practice had systems in place to identify, assess and manage risks related to the service through a series of internal checks and audits. We were provided with documentation relating to waste management contracts and health and safety risk assessment and audits conducted by the practice. We saw a copy of a recent monthly performance review, which confirmed a range of checks had been undertaken. These included risk profiles, health and safety assessments, infection control audit, building and equipment maintenance. The review was carried out by the practice manager and refreshed monthly.

Medicines Management

We looked at the storage of medicines held by the practice and observed that stock was securely stored in a locked cupboard and was in date. Records showed that a member of the nursing staff checked the medicine cupboard daily. We reviewed documents relating to a nurse led monthly medicines audit and saw that any medicines due to expire within the next two to three months were re-ordered in advance.

Appropriate temperature checks for refrigerators used to store vaccinations and other types of injections were carried out and recorded daily during working hours. The practice had a contingency plan in place if fridge temperatures fell out of range, as vaccinations were required to be stored at the correct temperatures recommended by the manufacturer to maintain their potency.

Prescription pads were kept safely in locked rooms and cupboards away from the risk of theft and abuse. A log of prescription numbers in and out was maintained and prescription pad audits conducted annually.

Cleanliness & Infection Control

We observed the premises to be generally clean and tidy with the exception of the room that housed the surgery pod system, which was cluttered. Clinical rooms were uncluttered, well lit and clean, but we did note that some high level storage shelves and window ledges were dirty. There were sharp bins seen in all clinical rooms and the correct clinical and domestic waste disposal arrangements were in place. We observed that one of the alcohol gel dispensers in place had expired, but were assured by staff that this had been ordered and was awaiting replacement.

A contract cleaning company was responsible for the cleaning of the building and non-clinical equipment each weekday evening. Recent cleaning schedules supported this. There was evidence of a recent completed spot check audit against these schedules. The practice maintained a message book in which they communicated with the contracted cleaning service to ensure any concerns or requests were acted upon. We were told that clinical equipment and furniture within consultation rooms was cleaned by nursing staff. We did not see a clinical cleaning schedule to support this.

The practice had an identified nurse lead for infection control and cleanliness. We saw evidence that nursing and support staff had completed infection prevention and control training which included hand hygiene techniques. We did not see evidence to support that GPs had completed this training. An NHS infection, prevention and control tool kit was used by the practice to assess and monitor the infection control systems in place. We were provided with evidence of the last audit completed in January 2014.

Staffing & Recruitment

The practice had an up to date recruitment policy, which reflected safe and effective practices when recruiting staff. There were formal processes in place for the recruitment of staff to check their suitability and character for

Are services safe?

employment. Recruitment checks had been performed for all staff who worked at the practice. These included Disclosure Barring Service (DBS) checks, personal references and right to work in the UK. Registration checks of clinical staff with professional bodies such as General Medical Council (GMC) and Nursing and Midwifery Council (NMC) were also completed. Clinical staff had undertaken the relevant occupational health checks to ensure that they remained up to date with necessary vaccinations.

The practice management team told us that they were confident that the practice would be able to respond to busy periods and staff shortages. They described current flexible working arrangements with staff, which allowed staff to cover at busy times and reduce the need for locum staff.

Dealing with Emergencies

The practice had arrangements in place for dealing with medical emergencies. All staff had received training in cardio-pulmonary resuscitation (CPR) including defibrillator training. We saw that each clinical room had a panic alarm linked to reception area and this was used to call for help in an emergency. However one unmanned room in which the surgery pod was housed and patients had access to did not have a pull cord alarm, meaning that patients who used the room may not be able to signal for help in the event of an emergency.

Clinical and support staff told us that if the emergency alarm was raised they would collect the emergency bag containing oxygen, defibrillator and emergency drugs and take them to the room where the alarm had been raised. We observed the resuscitation trolley was kept in a storeroom on the ground floor and all staff had access to it. The trolley was mobile on wheels so it could be easily moved to a medical emergency if required. There was no evidence of any real time emergency response drills. Emergency medicines and equipment were checked regularly and emergency medicines were in date.

Equipment

We saw records that demonstrated equipment used at the practice was maintained appropriately. Maintenance contracts were in place to ensure that equipment used in the practice was regularly tested and repaired when necessary. Portable appliance testing (PAT) had been carried out in line with legal requirements and that annual calibration testing of medical equipment had been conducted. We observed that oxygen cylinders were regularly checked and that fire extinguishers were validated.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice had measures in place to promote best practice. There were regular mandatory clinical meetings for discussion of educational topics and guidelines to ensure clinical staff remained up to date with current evidenced based medicine.

The practice attended NHS West London Clinical Commissioning Group (CCG) led clinical learning set meetings that reviewed data from other practices in the area and allowed comparison of outcomes and benchmarking. This meant the practice could compare their performance with other practices and use this to drive improvement.

All staff had appropriate induction training and engaged in regular appraisal. This allowed for review of performance to identify areas for improvement and plan training accordingly.

The practice engaged with other local allied professionals to ensure the best integrated care was delivered to their patients. There were monthly multi-disciplinary team meetings with a range of health and social care professionals to discuss and plan care for high need patients.

The practice had a pro-active approach to health promotion by inviting patients to NHS health checks, providing a surgery pod for patients to check their own blood pressure and weight and by running a variety of health promotion clinics including smoking cessation.

Our findings

Promoting Best Practice

The practice had procedures in place to promote best practice. There were regular clinical meetings that were mandatory for all clinical staff to attend. These meetings included discussion of clinical guidelines and educational updates. This gave clinical staff the opportunity to keep up to date with current evidenced based medicine. We were told the GPs attended five study days per year to continue their learning and development. In addition to meetings and study days, clinical knowledge summaries and National Institute for Health and Care Excellence (NICE) guidelines were attached to the GP notes system to ensure the GPs had access to up to date evidence when seeing patients.

Management, monitoring and improving outcomes for people

The practice participated in clinical audits to drive service improvement and provide best practice care and treatment. We saw evidence that the practice acted upon results of clinical audit. The practice had undertaken medicine prescribing audits in conjunction with the local prescribing incentive team. A prescribing pharmacist attended the practice regularly as part of their work with the NHS West London Clinical Commissioning Group (CCG) to monitor and improve prescribing practices. We saw the practice's latest prescribing improvement plan for 2013/14, which detailed the actions required to improve upon the performance of compulsory quality indicators.

The practice participated in the Quality and Outcomes Framework system (QOF). QOF is a voluntary incentive scheme for GP practices used to monitor the quality of services provided against groups of key performance indicators to improve practice.

The practice attended CCG led clinical learning set meetings with other local GP practices to discuss current clinical and organisational issues. This allowed comparison of outcomes and benchmarking with other health practices. One of the GPs acted as lead CCG representative and attended CCG wide meetings. This meant that the practice compared their clinical activities with that of other local GP services and findings were used as a focus to drive improvement.

Are services effective?

(for example, treatment is effective)

Staffing

The practice had an induction process that included clinical and administrative checklists for newly employed staff. The process however did not include any detailed learning objectives. We discussed this with management staff and were told that in addition to the induction schedule, a new member of staff would also receive a weekly induction plan. This plan included protected time for meeting colleagues and external health care partners and time to shadow colleagues in their roles.

There were measures in place to promote continued professional development of all practice staff. We saw evidence of annual staff appraisal. GPs undertook appraisal as part of the General Medical Council (GMC) revalidation process. Revalidation is the process by which all licensed doctors have to demonstrate to the GMC that they are up to date, fit to practice and compliant with relevant professional standards. In addition they also received practice based appraisal against agreed objectives. We saw an example where one GP had identified a learning need that was met through clinical sessions with a consultant at a local hospital.

Nursing staff appraisals were conducted annually and led by the practice manager with input provided by the GP partner. Nursing staff told us that they found appraisal helpful and felt able to ask for training as required. Following their appraisal, a practice nurse had attended a diabetes conference to learn more about long-term management and support of patients with diabetes. Administration staff appraisals were planned annually by the practice manager and included a personal development plan.

The practice had a disciplinary policy, which included dealing with poor performance. The practice manager told us that poor performance was identified wherever possible and managed through the most appropriate path.

We observed that nursing staff at the practice did not participate in formal clinical supervision. Clinical case reviews, serious incidents and complaints relating to clinical work were investigated by the GP partner and practice manager and discussed with all clinical staff and actions agreed.

Working with other services

We saw evidence of collaborative work between the practice and a range of other allied health care professionals. The practice held monthly multi-disciplinary meetings that included attendance from district nurses, health visitors, mental health workers allocated to the practice and social workers. We were told these meetings were to be extended to include attendance from local palliative care team members. The meetings were used as a forum to discuss the care requirements of high need patients and to develop integrated care pathways to support their needs.

Agenda items also discussed at the meetings included any changes to services, updates to district nurse patient lists, new medicines or vaccines available and any significant incidents or deaths.

We were told that GPs at the practice were able to email for specialist advice and guidance from different clinical disciplines at a local hospital. We were told this service was set up as a pilot by the GP partner and had been extended to include a large number of clinical disciplines. These included cardiology, elderly medicine, paediatrics, vascular, stroke and gastroenterology specialities.

The practice held an in-house anti-coagulation clinic which was a hub service providing INR testing and treatment for patients taking warfarin medicine from ten other local GP practices. We were told that the clinic had good links with secondary care haematology services and fostered joint working between local GP practices.

The practice worked with local voluntary, community and allied health partners to develop a range of integrated extended on-site services to meet the specific needs of their patients. These included a primary care navigator (PCN) to assist patients aged 55 years and over and their carers in accessing health, social care and voluntary sector services in the community.

The practice was also part of a local neighbourhood forum, which included representation from local services including health. We were told it was sometimes difficult for members of the practice to always be present at these meetings, but that the practice responded to agendas and minutes from meetings if unable to attend.

Health Promotion & Prevention

The practice had measures in place to support the needs of patients in health promotion. Patients between 45-65 years were invited to attend health check appointments with the practice nurse. This involved reviewing a person's weight, blood pressure and lifestyle habits and for any abnormal

Are services effective?

(for example, treatment is effective)

values or concerns to be referred to the patient's usual GP. These checks gave clinicians the opportunity to promote healthy lifestyle choices to patients and help set goals to achieve them.

In addition to health checks a surgery pod was accessible for patients to use at the practice without the need for an appointment. The surgery pod was a touchscreen computer that enabled patients without clinical supervision, to measure their own vital signs for example, blood pressure and pulse rate, or basic information including weight and height. It was configured to the practices electronic patient record system so that information was automatically recorded into the patient's medical record. An alert was built into the system to warn if vital signs fell outside the normal range and required urgent review by the practice nurse or GP. This gave patients the opportunity to take control of their health and to identify anyone who may need intervention or advice regarding health lifestyle choices.

Other health promotion services provided at the practice included nurse led smoking cessation clinics and sexual health screening. The practice GPs gave twice yearly talks to patients, which covered a wide range of health topics including health promotion information. The practice was also involved in a local health initiative called 'My Action Plan', which was a three month diet and lifestyle programme for patients identified at risk of heart disease.

Are services caring?

Summary of findings

Staff were observed being courteous and approachable and patients felt they were treated with respect.

Consultations took place in appropriate rooms that maintained patient's privacy and dignity and there was ready access to chaperone service for examinations if required. Patients felt they received compassionate care and were treated with dignity.

The practice took measures to ensure patients were involved in decisions about their care. There was a range of information leaflets for patients on health topics to support decision making and these were available in different languages. Patients felt they were involved and supported to make decisions about their care.

Our findings

Respect, Dignity, Compassion & Empathy

The results of the GP patient survey published by NHS England in December 2013 indicated that 89 percent of respondents were satisfied overall with the service they received from the practice. A high level of satisfaction was indicated with the care and concern shown by clinical staff and with the explanations and information they provided about tests and treatment. Similar findings were reported in the latest annual patient survey conducted by the practice. 95 percent of patients who participated considered clinical staff to be supportive, caring, informative and helpful.

During our inspection we observed that staff were kind, courteous and approachable when dealing with patients attending the practice in person or by telephone. Patients we spoke with generally felt that staff were respectful and polite and considered that they received compassionate care and were treated with dignity. Although it was brought to our attention that visually impaired braille users had difficulties in accessing toilet facilities if not made aware of their location on arrival at the practice.

Consultations took place in appropriately equipped rooms that maintained patient's privacy and dignity. Patients had access to a chaperone service when they underwent an examination. Information was displayed in the waiting area if patients wanted to request a chaperone during an examination. We were told that nurses usually fulfilled this role. New patients registering at the practice were provided with the opportunity to choose a male or female doctor as their usual GP.

The practice had procedures to follow in the event of the death of one of their patients. This included notifying other agencies and professionals who had been involved in the patients care, so that any planned appointments, home visits or communication could be terminated in order to prevent or cause relatives any additional distress. Information was available to direct people to bereavement support services.

Involvement in decisions and consent

Patients told us that they had been involved in decisions about their care and treatment and were supported to make informed choices. They told us their treatment was fully explained to them and that they understood the

Are services caring?

information given to them. Clinical staff confirmed that they always endeavoured to discuss and explain to patients their treatment options and used relevant literature were appropriate to assist understanding.

There was a range of information leaflets available to patients on subjects including health topics to support decision making. We were shown that these leaflets were available in a number of different languages. The practice website provided a patient health information page with links to websites for specific health related conditions and support organisations.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had measures in place to respond to and meet the needs of their patient population. The practice ran clinics for specific population groups including families with young children, people with learning difficulties and their carers and clinics for chronic disease management. They had clear pathways and access to dedicated services to support vulnerable population groups including people with drug misuse problems and the frail elderly.

The practice had an open access policy for all and each patient had a named GP. The 'Talk to your GP' system allowed patients to ring up and arrange for a call back from their usual GP on the same day for medical advice. Appointments could be requested online for non-urgent issues via the 'email your GP' facility on the practice website. Emergency issues were dealt with by same day urgent appointments or home visits.

The practice had a clear policy and procedure for complaints and patient feedback was encouraged. Complaints were reviewed at the weekly GP meetings and any learning points were disseminated to all staff.

Our findings

Responding to and meeting people's needs

The practice had measures in place to respond and meet the needs of the patient population they supported.

According to figures provided in the Patient Reference Group (PRG) Report 2013; 24 percent of the registered population profile are aged 0–16. Approximately 20 percent of the practice patient list are provided with enhanced care under the Westminster local enhanced homeless scheme. Approximately two percent of the practice population have serious mental health issues, over one percent of patients access shared care services for substance misuse problems and approximately one percent of patients have a learning disability.

The practice ran a weekly child health and well-baby clinic and a child and baby emergency morning walk in service for children up to ten years of age. Family planning, maternity care and gynaecological examinations were available for women and young people to access. The practice operated an open access policy in which people without an address could access services offered by the practice.

The practice ran clinics for patients with learning difficulties and their carers, for health checks, immunisations and dietary advice. A comprehensive service for the management of chronic diseases including; asthma, chronic obstructive pulmonary disease (COPD), heart disease and stroke prevention, diabetes, hypertension as well as for mental health problems such as depression and anxiety was also provided by the practice.

The practice had a dedicated service to meet the needs of patients with drug misuse problems. Two substance misuse workers, a trained mental health nurse and a generic drug worker worked alongside the practice team.

The practice had access to a wide range of services to support the needs of older patients in their patient population. They were able to refer to the older person's rapid access clinic (OPRAC). The clinic provided same day or next day appointments for frail elderly patients who required urgent geriatric assessment. The practice could also refer elderly patients who experienced progressive undiagnosed cognitive impairment including memory problems, to Kensington & Chelsea and Westminster memory service for a cognitive assessment and diagnosis.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had onsite interpreters and had access to interpreting services if required.

Access to the service

All patients registered at the practice had a named GP they could contact and access. The practice operated a 'Talk to your GP' appointment system. Under this system when a patient needed to consult their GP with a non-urgent issue, they would contact the practice to book a telephone call back with their GP. The call back time would be agreed with the patient within two to three hours after the initial call was made. The GP then contacted the patient to discuss the issue and either resolve it there and then, agree the best plan of action or arrange a face to face consultation appointment.

Home visit requests for patients unable to attend the practice were triaged in the same way. Urgent problems or emergencies were dealt with immediately through someday bookable or walk in appointments to see the duty GP. Advance appointments to see the GPs and practice nurses were booked through reception. Appointments could be requested online for non-urgent issues via the 'email your GP' facility on the practice website. Patients also had the opportunity to access their usual GP or practice nurse with non-urgent medical concerns by email with a response provided within three working days. We noted that there were no GP face-to-face appointments for patients to access outside of normal working day time hours.

The call back system we were told was designed to make it easier for patients to access their own GP and to provide the opportunity for longer appointments with the GP if needed. However, some patients we spoke with did not favour this appointment system. Some patients communicated to us that it was hard to get a face-to-face appointment with their GP because of the system. A further issue of concern was that if a patient missed the GP call back, then the GP would not call again and that the process would have to be repeated the following day. We discussed this with the practice manager who informed us that that if a patient could not be contacted the GP would attempt to contact the patient again.

The practice operated an open access policy. We were given examples of how patient groups who may experience difficulty in accessing medical services could be seen at the practice without encountering any stigma or negative attitude. People for example did not have to be registered at the practice or have an address to be seen. A 'Walk in Access' Card system was used to ensure that very vulnerable patients had access to medical care as and when it was needed.

We were made aware of two local community services with strong links to the practice. Both these services assisted vulnerable groups of people to access primary health care services offered by the practice. These groups included women who worked in the sex industry, people who were homeless or moved around and people dependent on drugs and alcohol. We spoke with the management of both these services who described positive and flexible access for people they directed to the GP practice.

There was access to the practice for wheelchair users including lift access to the upper floors of the building. A hearing loop system was in place and the practice had onsite interpreters as well as the use of external interpreting services.

Concerns & Complaints

The practice had a complaints policy and procedure that was explained in an information leaflet available in the reception and waiting areas in the practice. The information described the complaints process from how to make an initial complaint to making formal complaints and the expected time response.

We were told and saw that complaints were a standing agenda item of the weekly GP meeting held at the practice. The practice also produced an annual complaints report analysis which detailed the complaints received for the previous year, the actions taken and lessons learnt.

Feedback from patients was actively encouraged. The practice manager held monthly 'meet the manager' drop in coffee mornings for patients to attend and express and discuss any issues or concerns. Feedback forms were available in the reception and waiting areas for patients to complete.

The practice had an established patient reference group (PRG) which fed back concerns and issues to the practice.

Are services well-led?

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

Summary of findings

There was a clear vision and strategy for the practice that all staff were aware of and understood. There was strong and visible leadership from the GP partner and practice management. The practice had governance arrangements in place including a range of internal checks and audits to monitor performance. There were regular management meetings to discuss organisation issues of the practice. There were systems in place for monitoring quality and improvement including internal peer review of secondary care referrals to ensure patients received the best and appropriate care to meet their needs.

The practice ran a patient reference group (PRG) to gather feedback from their patient population and ensure they were involved in decisions about the range and quality of services provided. They also received feedback from the annual patient survey conducted locally by the practice and from national feedback surveys. Staff at the practice felt generally well supported and listened to. They had the opportunity to engage with management and provide feedback at team practice meetings.

There was a culture of learning from complaints and significant incidents at the practice. Complaints reports and significant event analysis reports were produced detailing learning points and action plans put in place to improve the service.

The practice had measures in place to anticipate and manage risk including procedures to cope with any significant disruption to service.

Our findings

Leadership & Culture

The practice had a clear vision and strategy which we were told was; 'to provide the best possible care to everybody who needs it regardless of age, ethnicity, legal status, occupation, health and social care needs'. Clinical and non-clinical staff we spoke with were aware and understood this strategy. We were informed by staff that the surgery aspired to work with people who were vulnerable and hard to reach.

The practice had strong and visible leadership from the GP partner and the practice management team. The practice GPs held delegated responsibility for specific clinical areas including a range of long term conditions that the patient population experienced, as well as for medicine prescribing and women's health.

GPs we spoke with were supportive with the ethos of working with a 'Duty of Candour'. They told us of the importance of establishing a trusting relationship with the patient which was based upon honesty. They gave us examples of when this had been put in practice. One GP described an occasion when they had agreed with a patient that they would seek advice regarding diagnosis and treatment of a non-urgent concern, but this was not carried out. As a result the GP immediately apologised to the patient and agreed a new time frame with them.

Governance Arrangements

The practice had governance processes in place to monitor the quality of the service and to identify and manage risks to the service through a range of internal checks and audits. Internal audits were performed including infection prevention and control, building and equipment maintenance, and health and safety audits There were comprehensive policies and procedures in place. These included health and safety at work, reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR), emergency incidents, fire safety and infection control.

The practice manager met fortnightly with the GP partner to discuss all aspects of the practice organisation and management and any emerging issues. Regular practice meetings took place with involvement of staff at all levels.

Are services well-led?

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

Systems to monitor and improve quality & improvement

We saw evidence that the practice had mechanisms for systematic monitoring of quality and performance of the service. There was a monthly operational monitoring report, which demonstrated the current status of a range of key performance indicators. The report was refreshed monthly and the data used to reflect and improve upon practice.

The practice participated in the Quality and Outcomes Framework (QOF) system and participated in continuous clinical audit review in line with QOF requirements. This was used to monitor the quality of services and drive service improvement. All referrals made by the practice GPs to secondary services were peer reviewed, with the exception of suspected cancer and deep vein thrombosis (DVT) referrals, which were automatically processed. Referral reviews we were told were performed to ensure their appropriateness and would be re-directed to more suitable community services if considered applicable. This demonstrated that the practice had a system in place to monitor their referral pathways and ensure patients were referred to the most appropriate service to best meet their needs and improve outcome.

Patient Experience & Involvement

The practice took active measures to involve and take into account the experiences of their patient population and that their feedback was used to bring about positive changes and improvements to the service and care delivered.

The practice ran a patient reference group (PRG) which operated mainly as an email based forum, with two open meetings held annually. The main aim of the PRG was to ensure that patients were involved in decisions about the range and quality of services provided by the practice. The practice ran continuous recruitment campaigns to increase member numbers to ensure equitable representation of the patient population. The PRG annual report 2013 highlighted that that member representation was low among vulnerable patients such as those experiencing poor mental health and Arabic speaking patients. In response an action plan had been put in place to encourage practice staff who dealt directly with these patient groups to raise awareness of the PRG.

The PRG was involved in the format design and analysis process of the practice's annual patient feedback survey.

We saw evidence to support that issues highlighted in the patient feedback survey were incorporated into the practice improvement and development plan agreed with the PRG. We saw for example, some respondents to the 2013 patient survey had cited waiting times in clinics as a problem. As a result an action plan had been implemented by the practice to ensure that reception staff kept patients informed when clinics were running late. This included providing patients with the reason why, estimated wait time and options to re-book if necessary.

Staff engagement & Involvement

Staff we spoke with generally felt supported, valued and motivated and felt that they were treated fairly and that their opinions were listened to and taken into account. Practice team meetings attended by all staff were held quarterly and administration staff meetings held weekly during which any issues, concerns and pressures were discussed.

We were told that staff at all levels were included in educational opportunities provided by external partnership agencies to raise awareness of issues experienced by vulnerable groups and to enable staff to engage in educational learning to assist them in their roles. For example a representative form a local sexual health clinic presented education sessions to the practice team to inform and update them on time relevant issues.

A whistleblowing policy was available for staff to follow if they needed to raise concerns about the service. We were shown this policy and it included who staff should contact within the practice to discuss their concerns. Staff we spoke with confirmed their understanding of the policy and felt that they would be supported in raising concerns.

Learning & Improvement

The practice embraced a culture of learning from patient experience , complaints and significant incidents that had occurred at the practice

The practice had a formal significant incidents review process to reflect and learn from incidents in a structured way. Significant incidents were discussed at weekly GP practice meetings. A bi-annual significant events analysis was also carried out when each incident was graded major, intermediate or minor. We saw records of the most recent

Are services well-led?

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

analysis which documented significant incidents that had occurred during the period October 2013 to March 2014. This included detail of the actions and learning that the practice had concluded.

An annual complaints report was also produced by the practice that provided an analysis of the complaints received in the previous year. We reviewed the complaints report for 2013/2014 and saw that this included the actions and learning from complaint investigation reviews, along with improvements that had been made to the service as a result.

We saw records of regular staff training and appraisal. During staff appraisal personal development plans were established for the coming year these were used to identify any annual or mandatory training which needed to be completed by staff members.

Identification & Management of Risk

The practice had plans in place to deal with any significant disruption to services. The practice had a current business continuity plan. The plan included types of potential business failures, management of practice closure and identification of alternative premises in the event of catastrophic damage to the surgery. We were informed that a 'buddy' practice had been identified and work had begun to allow the two practices to support each other in the event of requiring interim alternative premises. We were provided with real time examples of how the practice had managed when services had been partially disrupted such as partial loss of power, loss of access through damage to front entrance and an episode of flooding.

Older people

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

Summary of findings

The practice had measures in place to support the needs of older patients in their practice population. All patients over the age of 75 years had a named GP.

They had access to a wide range of services including older person's rapid access clinic (OPRAC) with same or next day assessment for frail elderly patients by secondary care and access to memory service assessments.

The practice had access to a Primary Care Navigator (PCN) who could support older patients in accessing health, social care and voluntary sector services in the community.

Our findings

All patients over the age of 75 years had a named GP.

The practice had access to a wide range of services to support the needs of older patients in their practice population. They were able to refer to the older person's rapid access clinic (OPRAC) at Charing Cross and St Mary's Hospitals, which was a pilot clinic, set up by secondary care to support GPs in the management of frail older people. This included a rapid access clinic that provided same day or next day appointments for frail elderly patients who required urgent geriatric assessment.

The practice was able to refer elderly patients who experienced progressive undiagnosed cognitive impairment including memory problems, to Kensington & Chelsea and Westminster Memory service for a cognitive assessment and diagnosis. This provided the practice with a pathway to assess and meet the needs of the frail elderly in the community to minimise unnecessary admissions to hospital

The practice had access to a Primary Care Navigator (PCN). The PCN provided patient-centred support for patients 55 years and over, as well as their carers, in accessing health, social care and voluntary sector services in the community. They played a role in providing information and advice, reducing social isolation, co-ordinating care and improving planned take up of services.

The practice provided information leaflets relating to a local charity, which ran classes and health promotion for patients over the age of 50.

People with long term conditions

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

Summary of findings

The practice had measures in place to support and meet the needs of people with long-term conditions in their practice population.

Patients with a chronic condition had a named GP as a clear point of contact for the management of their medical needs. The practice held monthly multi-disciplinary team meetings with a range of allied health professionals to plan integrated care pathways for patients with chronic and complex needs. A rolling programme of call and recall was maintained for influenza vaccination uptake.

Our findings

A comprehensive service for the management of chronic diseases including; asthma, chronic obstructive pulmonary disease (COPD), heart disease, stroke prevention, diabetes and hypertension were provided by the practice. Patients with long-term conditions had a primary nominated GP for the specific condition and all follow-ups and queries would be directed to this GP. This provided patients with a clear point of contact for the management of their condition.

Monthly multi-disciplinary team meetings were held to discuss patients with complex medical problems. At these meetings, detailed care plans and integrated care pathways were developed to meet care needs. This provided patients with long-term medical conditions with access to appropriate allied health professional services.

We were told that the practice invited patients for annual health checks and maintained a rolling programme of call and recall for influenza vaccination uptake.

Mothers, babies, children and young people

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

Summary of findings

The practice had measures in place to support and meet the needs of mothers, babies, children and young people.

The practice ran a weekly child health and immunisation clinic provided jointly by a GP, practice nurse and health visitor to support the needs of families with babies and young children. A monthly specialist child health clinic with a paediatric consultant was also held, which other local practices could refer to. There was a child and baby emergency walk in service daily to ensure access to urgent care if required.

The practice ran health promotion clinics for mothers and young people including family planning, ante-natal and post-natal care and smear testing.

Our findings

The practice held a joint weekly child health and immunisation clinic provided by a GP, practice nurse and health visitor attached to the practice. A monthly specialist child health clinic with a paediatric consultant was also held. This provided an on-site clinical hub for children's services which other local GP practices could refer to. The project was initiated jointly as a pilot by the GP partner and a paediatric consultant from a local hospital trust and has since been extended. We were told the clinic offered multidisciplinary team learning meetings as well as joint appointments with a consultant Paediatrician and the GP in the community.

A child and baby emergency walk in service was available daily until 11:30 am.

Family planning; including emergency contraceptive advice, ante-natal and post-natal care and gynaecological examinations; including smear testing, were also available at the practice for women and young people to access.

A children's play area was located on the ground floor reception area, baby changing facilities and a parent and baby room was available for use.

Working age people (and those recently retired)

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

Summary of findings

The practice head measures in place to support and meet the needs of working age people in their practice population.

The practice had a range of methods for patients to contact their usual GP without attending the practice, including email and telephone advice, to ensure health care was accessible to patients of working age. There were no face-to-face GP appointments for patients to access outside of normal working day time hours.

Our findings

The practice had various methods available for contacting the GP and making appointments. For example, routine queries could be emailed to the GP or appointments could be booked online. The 'Talk to your GP' appointment system meant patients could request a call back from their GP at a time suitable to their day. There were no face-to-face GP appointments for patients to access outside of normal working day time hours.

An on-site counselling service was available for patients to access.

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

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

Summary of findings

The practice had measures in place to support and meet the needs of people in vulnerable circumstances.

The practice had a long standing open access arrangement to treat people in vulnerable circumstances and ensure they did not encounter any negative attitudes.

The practice ran specific clinics to support patients in vulnerable circumstances including joint clinics for patients with learning difficulties and their primary carer. The practice had integrated extended on site services to support the needs of people with drug misuse problems.

Our findings

The practice had measures in place to support and meet the needs of people in vulnerable circumstances.

Joint clinics for patients with learning disabilities and their primary carer were held with the practice nurses. These clinics reviewed their health needs and provided health checks, immunisations and dietary advice.

We were told by staff that the practice had a long standing open access arrangement for treating vulnerable patient groups and promoted this to ensure these patients did not encounter any stigma or negative attitudes. Access to the practice was available to people who worked in the sex industry and to people who were homeless or moved around. A 'Walk in Access' Card system was used to ensure that very vulnerable patients had access to medical care as and when needed.

The practice had integrated extended on site services to support the needs of people with drug misuse problems. Two substance misuse workers, a trained mental health nurse and a generic drug worker worked alongside the practice team. We were told the team had regular meetings to discuss patients who used the service and their on-going needs.

People experiencing poor mental health

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

Summary of findings

The practice had measures in place to support and meet the needs of people experiencing poor mental health in their practice population.

The practice had on-site access to a community psychiatric nurse and an on-site counselling service was available. The practice maintained a rolling programme of cervical screening call and recall for female patients in this population group.

Our findings

The practice had services for the management of people experiencing poor mental health.

The practice had on-site access to community psychiatric nurse and a graduate mental health worker to support the needs of patients with a mental health problem. An on-site counselling service was available for people with anxiety or depression. The practice maintained a rolling programme of cervical screening call and recall for female patients in this population group.