Third Floor Lanark Road Medical Centre

Quality Report

3rd Floor Medical Centre
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Third Floor Lanark Road Medical Centre on 27 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for the six population groups: older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances may make them vulnerable; and people experiencing poor mental health.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients said they were treated with dignity and respect, and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to access the service, with urgent appointments available the same day and a weekend walk-in clinic.
- There was a clear leadership structure and staff felt supported by management.

We saw one area of outstanding practice:

- The practice was responsive to the needs of their population, which resulted in better outcomes for their patients. The practice's patient population consisted of a high proportion of Middle Eastern patients who spoke Arabic and did not have English as a first

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language. Even though two of the GPs spoke Arabic, the practice had employed an interpreter to attend the practice every weekday to assist these patients with written and verbal communication.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site.

Importantly, the provider should:

- Formalise their vision and values and share these with patients and staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Lessons were learned and communicated with the practice team to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe. However the practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and had not undertaken an assessment of the risk this might pose.

Are services effective?

Good

The practice was rated as good for providing effective services. There were systems in place to ensure that national guidelines and other locally agreed guidelines were used to influence and improve patient outcomes. The practice regularly met with other health professionals to coordinate care, and networked with local providers to share best practice. Clinical audits were undertaken and reflected areas relevant to the practice to improve the quality of services provided. Staff had received training appropriate to their roles. Appraisals and personal development plans were undertaken for all staff.

Are services caring?

Good

The practice was rated as good for providing caring services. Patients said they were treated with dignity and respect, and they were involved in their care and decisions about their treatment. Data from the National GP Patient survey showed that respondents rated the practice lower than others for some aspects of care, such as clinical staff explaining tests and treatment. The practice had taken into account feedback for improvement, and we found examples to demonstrate how people's preferences were valued and acted on. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. The needs of the practice population were understood and services were planned to ensure these needs were met. Even though two GPs spoke Arabic, the practice employed an interpreter who attended the practice every weekday to provide translation services to the high proportion of patients who spoke Arabic. Patients said urgent appointments were available the same day, and they were

Summary of findings

very satisfied with the weekend opening hours. Longer appointments were available for people who needed them. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was an active review of complaints to identify learning needs, and these were shared with staff.

Are services well-led?

Good

The practice was rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity, and these were accessible to all staff via the practice computers. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from patients and the patient participation group (PPG), and acted on this feedback. Staff had received inductions, performance reviews and received support to develop in their roles. Staff attended practice meetings and knew the lines of escalation to report incidents, concerns, or positive discussions. The practice had yet to formalise their vision and strategy and share this with staff and patients.

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 was rated as good for the care of older people. All patients over the age of 75 had a named GP and were informed of this in writing. The practice's appointment system allowed for longer appointment slots, telephone consultations, and home visits for patients over the age of 70. Multidisciplinary meetings were held to discuss older patients with complex needs, and the practice worked with other healthcare providers including district nurses and care navigators to coordinate patient care. The practice also offered vaccinations to older patients in line with current national guidelines.

People with long term conditions

Good

The practice was rated as good for the care of people with long term conditions. The practice worked with other healthcare providers to coordinate patient care. Monthly 'Village' meetings were held with other practices in the area and a multidisciplinary team, to discuss patients with complex needs including patients with long-term conditions, and palliative care patients. There was a palliative care register and the practice sent details of patients who were in receipt of palliative care to the out-of-hours service. A "Wellwatch" clinic was carried out by a nurse who visited the practice every week. Vulnerable patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes, and hypertension were referred to the clinic. The practice nurse provided chronic disease management reviews for conditions such as COPD, asthma, diabetes, and hypertension.

Families, children and young people

Good

The practice was rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children who were at risk, and child safeguarding meetings were held with the health visitor every two months or sooner if required. There were dedicated clinical leads for safeguarding children, and all staff had received relevant role-specific training in child protection. Longer appointments were allocated for antenatal and postnatal checks, and childhood immunisations were carried out by the GPs and nurse. All new patients registering with the practice were offered a health check with the practice nurse or the GPs, and young people aged 15-24 were routinely offered chlamydia screening during their health check. Appointments were available outside of school hours.

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Working age people (including those recently retired and students)

Good

The practice was rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was open 08:30 – 18:30 every weekday except Thursday afternoons when it closed. Extended hours were offered with the GPs from 18:30 to 20:00 on Tuesday evenings. The weekend walk-in clinic provided improved access for people who could not attend the practice on weekdays. Patients could book appointments online, over the phone, or in person, and emergency appointment slots were available daily. NHS health checks were offered to all patients between the ages of 40 and 74. This was an opportunity to discuss any concerns the patient had and identify early signs of medical conditions. Cervical smear tests were offered to patients in line with national guidelines. Travel vaccinations were administered at the practice, and health promotion material was also available to patients.

People whose circumstances may make them vulnerable

Good

The practice was rated as good for the care of people whose circumstances may make them vulnerable. There was a system to highlight vulnerable patients. A “Wellwatch” clinic was carried out by a nurse who visited the practice every week. The clinic was aimed at vulnerable patients with long term health needs and/or social problems to keep them well and avoid hospital admission. The practice held a register of patients with learning disabilities, and longer appointments were offered to these patients. Patients with a learning disability were supported to make decisions through the use of care plans, and these care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it.There was a system in place for identifying carers, and these patients were offered health checks and immunisations. There were clinical leads for safeguarding vulnerable adults, and staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including people with dementia). Longer appointments were offered to patients who might require them including patients with mental health conditions. Vulnerable

patients with conditions such as depression were seen at the "Wellwatch" clinic which was carried out by a nurse who visited the practice once a week. Counselling sessions were also available at the practice once a week. Two GPs looked after older patients who had advanced cognitive impairment or severe and enduring mental health needs at a local care centre. The GPs visited the care centre twice a week, and worked with other healthcare providers to coordinate patient care.

Summary of findings

What people who use the service say

We spoke with six patients and one member of the patient participation group (PPG). We also spoke with the manager of a local care centre for older people. We reviewed 45 CQC comment cards which had been completed by patients, data from the National GP Patient Survey 2014, and feedback from the practice surveys.

Patients we spoke with were happy with the cleanliness of the environment. Patients said staff always treated them with dignity and respect, and they were involved in their care and decisions about their treatment. Data from the National GP Patient Survey showed that respondents rated the practice lower than others for some aspects of care, such as clinical staff explaining tests and treatment. The practice survey showed that telephone access to the practice was an issue, and the practice had taken action to address this. The patients we spoke with told us they were satisfied with the opening hours, and in particular the weekend walk-in clinic.

The comment cards reviewed were all positive and said staff were caring and helpful when addressing patients' needs.

Areas for improvement

Action the service MUST take to improve

- Ensure availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site.

Action the service SHOULD take to improve

- Formalise their vision and values and share these with patients and staff.

Outstanding practice

- The practice was responsive to the needs of their population, which resulted in better outcomes for their patients. The practice's patient population consisted of a high proportion of Middle Eastern patients who spoke Arabic and did not have English as a first language. Even though two of the GPs spoke Arabic, the practice had employed an interpreter to attend the practice every weekday to assist these patients with written and verbal communication.

Third Floor Lanark Road 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 CQC Inspection Manager and a GP specialist advisor. The GP specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspectors.

Background to Third Floor Lanark Road Medical Centre

Third Floor Lanark Road Medical Centre, also known as Lanark Medical Centre, provides GP led primary care services to around 2,800 patients living in the surrounding areas of Maida Vale, Kilburn, and St Johns Wood.

The practice is located within the City of Westminster. The Indices of Multiple Deprivation (2010) shows that the City of Westminster was the 75th most deprived local authority (out of 326 local authorities, with the 1st being the most deprived).

The practice holds a General Medical Services (GMS) contract with NHS England for delivering primary care services to the local community. The practice has a higher proportion of patients between the ages of 5-19 and 30-54, when compared with the England average. The number of patients over the age of 60 is lower than the England average. The practice told us they have a transient population, and that there are a higher proportion of Middle Eastern and African patients registered with the practice.

The practice has a female lead GP partner, a male GP partner, and two sessional GPs (one male and one female). Other staff include a practice nurse, two practice managers, and a small reception/administrative team. The GPs collectively cover 18 sessions per week, and the practice nurse works 32 hours per week.

The practice is based on the third floor of a building it shares with another health care provider. The practice is open every weekday 08:30 to 18:30 except on Thursday afternoons when it closes at 13:30. A weekend walk-in clinic is offered to registered and non-registered patients from 10:00 to 18:00 under the new enhanced service. Extended hours are offered with the GPs from 18:30 to 20:00 on Tuesday. Appointments must be booked in advanced over the telephone, online, or in person. The practice opted out of providing out-of-hours services to their patients. On Thursday afternoons and outside of normal opening hours patients are directed to the NHS 111 service.

The CQC intelligent monitoring placed the practice in band 1. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

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.

How we carried out this inspection

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

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

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

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

Before our inspection we reviewed a range of information we hold about the practice. As part of the inspection process we contacted key stakeholders which included NHS Central London (Westminster) Clinical Commissioning Group (CCG) and Healthwatch Westminster, and reviewed the information they shared with us.

We carried out an announced inspection on 27 November 2014. During our inspection we spoke with a range of staff including: a GP partner; two practice managers; and two administrative staff. We observed how patients were being cared for and sought the views of patients. We spoke with six patients, and one member of the patient participation group. We also spoke with the manager of a local care centre for older people. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the practice's policies and procedures. We also reviewed seven patient records.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Records were kept of significant events that had occurred and these were made available to us. Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events. For example, we saw staff had documented an incident relating to a power failure and followed procedures to notify the relevant agencies involved.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. All incidents were recorded with details of the event, outcome and recommendations, and learning needs identified. Since January 2014 there had been six reported incidents, and we saw these had all been reviewed and resolved. For example, one incident involved the premises alarm being activated after a patient exited the building via an emergency exit. Following the incident practice security was addressed and staff were made aware of how the alarm system worked and reminded to close doors within the corridor to prevent patients exiting the building through the emergency exit. There was evidence that the practice had learned from these events, and staff told us educational needs were discussed during team meetings or informally with individual staff members. Clinical staff received patient safety alerts via email, and these were discussed with relevant staff when action was required.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. The GP partners were appointed as the lead and deputy lead for safeguarding vulnerable adults and children. They had received the necessary training to enable them to fulfil this role, for example Level 3 child protection training. All other staff were up to date with training in child protection and safeguarding vulnerable adults. For example, the other GPs and the practice nurse had received Level 3 child protection training, and non-clinical staff had received Level 1 training. Staff knew who the safeguarding leads were, how to recognise signs of abuse, and how to escalate concerns within the practice.

There were procedures for escalating concerns to the relevant protection agencies, for example the multi-agency safeguarding hub (MASH) for child protection. The contact details for MASH and the local adult safeguarding teams were kept at reception, and all the staff we spoke with were aware of this. The practice's safeguarding children policy required updating with the contact details for the MASH.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Clinical and child safeguarding meetings were held with the health visitor every two months, and we saw minutes to confirm that any issues identified were followed-up and the action taken documented.

A chaperone policy was in place, however there were no signs in the waiting room or consultation rooms informing patients about this service. Staff told us that most patients saw a female GP if they required an intimate examination. Reception staff we spoke to said they did not chaperone, and that this was done by the practice nurse.

Medicines management

Arrangements were in place to ensure medicines kept at the practice were stored securely and only accessible to authorised staff. There were procedures for ensuring that medicines were kept at the required temperatures, and a cold-chain policy to describe the action to take in the event of a potential failure. The fridge temperature was checked daily by the practice nurse or practice manager, and we saw up-to-date logs to confirm this. Emergency drugs were checked monthly and records confirmed these checks were up-to-date. We checked a random selection of vaccinations and medicines in the treatment room and medicine fridge and found they were stored securely and were within their expiry date.

There was a lead GP for prescribing who met regularly with the community pharmacist to conduct medicine reviews and ensure prescribing was safe and effective. Most repeat prescriptions were reviewed every three to six months. We reviewed five patient records where the GP had reviewed

the patient's health and managed their repeat prescription appropriately. For example, a patient with diabetes had received a blood test that checked their average glucose levels before a repeat prescription was issued. Repeat prescriptions could be requested in person, or by post and it was practice policy to process repeat prescriptions within 48 hours of a request being made.

Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance.

Cleanliness and infection control

We observed the premises to be clean and tidy. 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, and all staff had received training. Personal protective equipment including disposable gloves were available in each clinical room. The practice received an infection prevention and control inspection by an external organisation the day before our inspection. The practice was deemed compliant and scored 99%. There was one area identified as requiring improvement, and the practice had reported this to the NHS estates team for action. The practice had recently changed cleaning providers due to dissatisfaction with the previous cleaners, and cleaning schedules had been put in place. Disposal of clinical waste and sharps bins was managed by an external company. We saw evidence that a legionella risk assessment had been carried out in August 2014.

Equipment

Staff told us they had sufficient equipment to carry out their roles in assessing and treating patients. The practice manager told us that equipment was tested and calibrated annually. Records showed that testing and calibration was now due and the practice manager was aware of this. We saw that equipment such as blood pressure monitors had been calibrated.

Staffing and recruitment

The practice had recruitment policies that set out the standards it followed when recruiting clinical and non-clinical staff. Recruitment checks were undertaken for new staff prior to employment, and these included proof of identity, satisfactory references, qualifications, registration with the appropriate professional body, and a Disclosure and Barring Service (DBS) check. We reviewed a selection of recruitment files and saw evidence that appropriate recruitment checks had been undertaken for new staff prior to employment.

All new staff underwent a general induction, and we saw completed induction checklists in staff files. We were shown the electronic employee handbook that was available to all staff, and this included sections on health and safety, equal opportunities, and whistleblowing.

The practice manager informed us that the practice nurse would be leaving the service soon and that two new nurses, who were known to the practice, were being screened for the vacant practice nurse position.

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. There was a health and safety policy in place, and the employee handbook also contained general health and safety information for staff.

The NHS estates team who managed the building were responsible for maintenance of the premises. The practice manager told us that if there were any maintenance issues which required addressing, they would document this in a communication book which was reviewed by the estates team on a weekly basis. We saw evidence that recent issues had been logged and resolved, such as changing lights and repairing the buttons in the lift. If the matter was urgent the practice would contact the estates team or the relevant external organisation, and document the incident as a significant event. We reviewed three significant events which related to power cuts to the building. As a result the practice had contacted the estates team and electricity company, and a new generator had been installed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available, including access to medical oxygen. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and had not undertaken an assessment of the risk this might pose. Emergency medicines were available in a secure area of the practice. It was the responsibility of the practice

Good

Are services safe?

nurse or a practice manager to check that emergency equipment and medicines were within their expiry date and suitable for use, and we saw records to confirm monthly checks were taking place. All the medicines we checked were in date and fit for use, and all staff knew of their location.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Risks identified included loss of access to the building, failure of telecommunications and IT systems, and staff shortage. A copy of the document was provided to all staff to be kept off the premises where it would be accessible in the event of an emergency. The plan contained contact details for individual staff members, neighbouring medical centres, the estates team, and other maintenance companies.

Records showed that the annual fire risk assessment had been conducted by the premises management in December 2013, and the fire alarms were tested on a weekly basis by practice staff. Staff we spoke with were aware of the fire evacuation procedures and assembly point.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and the Medicines and Healthcare Products Regulatory Agency (MHRA) around treatment and prescribing. The practice also received regular updates from the Clinical Commissioning Group (CCG).

There were monthly clinical meetings between the GPs and nurse, however these were informal and not documented. The lead GP met regularly with the nurse to discuss patient test results and recall patients who required further care. The GPs also attended CCG meetings, and monthly 'village' meetings with other practices in the area. The 'village' meetings provided an opportunity for GPs to discuss complex cases where environmental and social issues were impacting on the patient's health, and these meetings were attended by a multidisciplinary team. We saw minutes to the most recent meeting where the practice had discussed four patient cases, and received input from the multidisciplinary team.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP 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.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a clinical commissioning group (CCG) led clinical audit looked at the prescribing of blood glucose testing strips for patients with Type 2 Diabetes. An action plan had been developed after the initial audit, and the audit cycle was completed five months later. The outcome showed that the practice had reduced the prescribing of test strips for patients with Type 2 Diabetes, and that patients had been encouraged to self-monitor their condition and use the minimum number of tests to improve control. Another completed audit looked at the management and treatment of patients with chronic obstructive pulmonary disorder (COPD) and heart failure, with the aim to reduce avoidable emergency admissions. Key outcomes of the audit showed that the practice had optimised treatment by changing patients' medicines, and that patients had been treated in line with NICE guidelines.

The practice informed us that audits relating to medicines management were also conducted with the assistance of the community pharmacist. The practice used the information they collected for the quality and outcomes framework (QOF), a national performance measurement tool, to monitor outcomes for patients. Last year the practice achieved 890/900 points as part of the QOF. This exceeded both the CCG average (875) and the England average (884).

Effective staffing

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

Staff received annual appraisals which identified areas for personal development and action plans on how these would be achieved. We saw that the practice nurse and one member of the administrative team had received their annual appraisal, and other staff were due their appraisal next year.

Working with colleagues and other services

The practice worked with other healthcare providers to coordinate patient care. Village meetings with a multidisciplinary team were held monthly to discuss patients with complex needs, including older patients, patients with long-term conditions, and palliative care patients. These meetings were attended by GPs, district nurses, social workers, care navigators, counsellors,

Good

Are services effective?

(for example, treatment is effective)

pharmacists, and substance misuse practitioners. The lead GP met with the health visitor every two months or sooner if required, to discuss any child protection cases and we saw minutes of these meetings.

Two GPs attended to patients with advanced cognitive impairment, including dementia, at a local care centre. Visits were carried out twice a week, and the GPs met with the nurse in charge to discuss patients' health needs. The GPs also met with the care centre manager to handover any concerns which required follow-up from other professions such as psychiatry.

The practice received blood test results and letters from the local hospital, including discharge summaries, both electronically and by post. Correspondence received by post was scanned on to the patient record system by the administrative team. We were told the reviewing GP, who checked the correspondence on a daily basis, was responsible for carrying out any follow-up actions.

The practice sent details of patients who were in receipt of palliative care to the out-of-hours service. Information from the out-of-hours service was received each morning by fax. This was passed to the GPs immediately to follow-up any requests made, for example a change to a patient's prescription.

Information sharing

Clinical staff were responsible for their own referrals and letters, and electronic systems were in place for making these referrals. Most referrals were sent via Choose and Book, which is an electronic referral service that provides patients with a choice of where they are seen for their first specialist appointment. Exceptions to this were patients warranting referral under the two week wait guidance.

The practice had signed up to the electronic Summary Care Record, which provides staff treating patients in an emergency or out-of-hours with faster access to key clinical information. Information explaining the Summary Care Record was made available to patients on the practice website, including an opt-out form should patients not want their clinical information shared.

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

Consent to care and treatment

Clinical staff we spoke with were aware of their duties in fulfilling the Mental Capacity Act 2005, and the Children's Acts 1989 and 2004. They also 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.

Two of the GPs attended to patients with advanced cognitive impairment at a local care centre. We spoke to the care centre manager who said that most patients had dementia and that the GPs had a full understanding of patients' needs. The centre manager told us that when patients were assessed as not having capacity to consent, the GPs would involve the patient's family, carers and the consultant psychiatrist in making decisions about care and treatment.

Health promotion and prevention

The practice met monthly with the CCG and their locality group to discuss the needs of the practice population. This information was used to help focus health promotion activity. All new patients registering with the practice were offered a health check with the practice nurse or the GPs. Young people aged 15-24 were routinely offered chlamydia screening during the health check. The practice carried out NHS Health Checks for patients aged 40-75, and information leaflets were available to patients in the waiting room. The practice had met their annual target of 20%, by offering the health check to 27% of eligible patients. Data showed that the uptake was low, which reflected the transient patient population, with 31 out of 185 patients in this age group taking up the offer of the health check since April 2014.

The practice's performance for cervical smear uptake was 71%, which was below the CCG average of 78%. The practice was aware of this and was trying to increase uptake by contacting patients. If patients did not want to undergo the screening, they were requested to sign a disclaimer form which stated they could still attend for screening if they changed their mind. The practice offered a range of immunisations for children, and travel and flu

Good

Are services effective?

(for example, treatment is effective)

vaccinations in line with current national guidance. The practice had provided flu vaccinations to 50% (134) of patients aged six months to 65 years in the defined influenza clinical risk groups. This was an increase from last year's (2013/14) uptake of 48%. Last year the practice had also provided the flu vaccination to 39% of patients aged 65 and older.

Patients could see a dietician who provided nutrition and life style options. Clinical staff also provided opportunistic health promotion advice during consultations, for example offering dietary advice, and exercise promotion. A smoking cessation service was also offered. The waiting room had health promotion information on display, and there was an area with leaflets available to patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey 2014, and practice surveys conducted in 2012-2013 and 2013-2014.

The completion rate for the National GP Patient Survey was 12% (52 out of 440 people responded to the survey). The results showed that 75% of respondents found the overall experience of the practice good (clinical commissioning group [CCG] average 83%). Interactions with the GPs were rated below the regional averages, with 77% of respondents saying the GP was good at listening to them (CCG average 83%), and 65% of respondents saying the GP was good at treating them with care and concern (CCG average 79%). Satisfaction scores on consultations with the nurses were below the CCG average. Sixty-eight per cent of respondents said the nurse was good at listening to them (CCG average 72%), and 67% said the nurse treated them with care and concern (CCG average 70%).

We received 45 CQC comments cards where patients shared their views and experiences of the service. All comments were positive. Patients said all staff treated them with dignity and respect, and were caring, helpful, and kind. Some patients said the GPs listened patiently to their needs and provided treatment such as medicines, or referral to other services when required. We also spoke with six patients and one member of the patient participation group. They all spoke positively about the care they had received at the practice, and said their dignity was always respected. The lead GP in particular was praised for understanding the needs of patients and for her caring approach when treating them.

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

The reception area where patients checked-in for their appointment was within the general waiting room, and there was little privacy for patients to speak with staff.

Reception staff told us that they could speak with patients in the area behind reception or a consulting room if required. However, we did not see any notices informing patients about it.

Care planning and involvement in decisions about care and treatment

Information from the National GP Patient Survey showed patients responses were below the regional average for questions relating to their involvement in planning and making decisions about their care and treatment. Data revealed 59% of respondents found their GP was good at involving them in decisions about their care (CCG average 71%), and 76% felt the GP was good at explaining tests and treatments (CCG average 78%). Results for the same interactions with nursing staff showed 50% of respondents said the nurse was good at involving them in decisions about their care (CCG average 59%), and 69% said the nurse was good at explaining tests and treatments, which was marginally below the CCG average of 70%.

Patients we spoke to told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. The comment cards we received reflected these statements from patients.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it.

Translation services were available for patients who did not have English as a first language, however we did not see any notices to inform patients of this. Translation services including sign language interpretation could be pre-booked, or a telephone interpreting service could be accessed the same day. The practice had arranged for an interpreter to attend the practice every weekday at designated times to assist patients who spoke Arabic. The interpreter was present during our visit and we saw that they helped patients with written and verbal communication. Some staff were able to speak other languages including Arabic, Gujarati, and Spanish.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

There was a system in place for identifying carers. Staff were aware of carers' needs and told us that carers were offered health checks and immunisations. We saw that the four patients who were registered as carers had received an annual health check, and two had received the seasonal flu vaccination. Information on the various avenues of support available to carers was displayed in the waiting room and on the practice website.

Patients could be seen by a counsellor who attended the practice every week. The counsellor met with the lead GP to initiate further interventions, such as referral to a consultant or a medicines review. Many patients we spoke to told us they had needed emotional support in the past, and that the practice was able to support them with their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the needs and challenges facing the practice population, and services were planned to ensure these needs were met. The GPs engaged regularly with the Clinical Commissioning Group (CCG) and the locality network of GPs to discuss local needs and service improvement. Multidisciplinary 'village' meetings were held every month to discuss patients with complex needs.

In response to a local CCG initiative, the practice offered a "Wellwatch" clinic which was carried out by a nurse who visited the practice every week. The clinic was aimed at vulnerable patients with long term health needs to keep them well and avoid hospital admissions. The practice referred vulnerable patients, such as those with social problems, or depression, or patients with long term conditions including chronic obstructive pulmonary disease (COPD), diabetes, hypertension, and cancer, to the "Wellwatch" clinic. The practice nurse provided chronic disease management reviews for conditions such as COPD, asthma, diabetes, and hypertension.

Patients could access a male or female GP. All patients over the age of 75 had a named GP and were notified of this in writing. Routine appointments with the GPs were 10 minutes, and the practice offered double appointments for patients who might require them, including patients with learning disabilities, mental health conditions, and multiple long-term conditions. Antenatal and postnatal appointments were also allocated additional time. Home visits and telephone consultations were available to patients who required them, including housebound patients and older patients.

Two of the GPs looked after 40-45 older patients who had advanced cognitive impairment or severe and enduring mental health needs at a local care centre. The GPs visited the centre twice a week, and liaised with the nurse in charge to receive an update on patients' conditions. We spoke to the care centre manager who told us that the GPs were helpful and had a full understanding of the needs of patients. The care centre manager said that the GPs were contactable out-of-hours and were extremely responsive to the needs of their patients. For example, the GP attended the centre when a patient required an ambulance so that they could provide the patient's medical history to the paramedics.

The lead GP led on antenatal and postnatal care. A weekly clinic for mother and baby checks was also offered by the GP and health visitor, and these clinics included the administering of vaccinations and routine checks.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The National GP Patient Survey showed 83% of respondents found it easy to get through to the surgery by phone, which was higher than the local average of 79%. However, this was not reflected in feedback from the PPG who highlighted telephone access as an issue. The practice took action by providing staff with training on all aspects of the phone facilities and designating extension lines for direct access to individual staff members. Patients we spoke with told us they were able to get through to the practice to make an appointment when they needed one. Other suggestions the practice had implemented included additional dietician clinics, and improving advertising of the opening hours.

Tackling inequity and promoting equality

The practice understood the needs of different groups of people to deliver care in a way that met these needs and promoted equality. For example, carers were offered health checks and information specifically for carers was displayed in the waiting room. The practice told us that their patient population consisted of a high proportion of Middle Eastern patients who did not have English as a first language. Even though two GPs spoke Arabic, the practice employed an interpreter who attended the practice every weekday to provide Arabic translation services. The interpreter assisted patients during consultations and with written documents such as registration forms and feedback questionnaires.

The practice was based on the third floor of a shared building. There was lift access for patients with mobility difficulties. Some areas of the practice (reception, waiting room, one consultation room) were not accessible to

Good

Are services responsive to people's needs?

(for example, to feedback?)

people with mobility difficulties. We spoke to reception staff about this and they told us that patients could wait and be seen in other areas of the practice where there was step-free access. Accessible toilets were also available.

Access to the service

Services were delivered in a way to ensure flexibility, choice and continuity of care. The practice was open every weekday 08:30 to 18:30, except on Thursday afternoons when it closed at 13:30 and patients were directed to the out-of-hours service. Extended hours were offered with the GPs from 18:30 to 20:00 on Tuesday. A weekend walk-in service was available 10:00 to 18:00 and the practice saw patients from other practices within the area in addition to their own patients under the new enhanced service. The weekend and evening appointments were useful for patients who could not access the practice during working hours. A number of emergency appointments were available each day, and patients were required to telephone the practice between 08:30-09:00 to book these. Patients we spoke with confirmed that they could see a GP on the same day if they were in urgent need of treatment.

Patients could book routine appointments online, over the phone, or in person. Outside of normal practice hours patients were directed to an out-of-hours service. Information about appointments was available to patients in the practice, on the website and in the practice leaflet. Patients we spoke with were very satisfied with the opening hours. This was also reflected in the National GP Patient survey where the practice was rated above the CCG average (88%), for respondents saying the last appointment they got was convenient (95%).

Appointments with the GPs were ten minutes. Longer appointments were available for people who needed them, including patients with multiple conditions, and patients with learning disabilities. Home visits and telephone consultations were made available to patients who needed one, including housebound patients and older patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. A practice manager was the designated staff member who handled all complaints in the practice.

We reviewed the four complaints received in the last two years and found these had been investigated and responded to in a timely manner. There was an annual review of complaints, which included how they were managed and how learning was implemented, and we saw minutes to confirm that these were discussed with staff. Staff told us that complaints were also shared during practice meetings. All the staff we spoke with were aware of the system in place to deal with complaints.

We saw that information on the complaints system was made available to patients in the practice leaflet, complaints and comments leaflet, and on the website. Some patients we spoke with said they were aware of the process to follow if they wished to make a complaint. Other patients told us they would be comfortable making a complaint if required, and would initially approach staff with their concerns. None of the patients we spoke with had ever needed to make a complaint about the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had yet to formalise their vision, strategy and practice values. Senior management were able to describe the practice's vision for improving services provided for patients and the proactive management of long-term conditions. Other staff spoke about delivering high quality care for patients and the importance of staff training in achieving this, however they were not aware if the practice had documented its vision and values. Nor had senior staff discussed the vision and values to seek staff opinion. We did not see any information on values displayed within the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were made available to staff on any computer within the practice. The policies we looked at had been reviewed and were up to date, with the exception of the safeguarding children policy which required updated contact details for the local safeguarding teams. Staff were aware of the practice's policies and how to locate them.

The management team consisted of the two GP partners and two practice managers. There was a clear leadership structure with named members of staff in lead roles. For example, the practice nurse was the infection prevention and control lead, and the GP partners were the safeguarding leads. We spoke with two members of staff and they were clear about their own roles and responsibilities. They all told us they felt supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for April 2013 – March 2014 showed that the practice had achieved 890/900 points, which was higher than the CCG and England averages.

The practice undertook clinical audits which it used to monitor quality and systems to identify where action should be taken. For example reviewing prescribing practices, and ensuring patients received treatment in line with national guidelines.

The practice had systems for identifying, recording and managing risks. Health and safety policies and a business continuity plan were in place, equipment was checked regularly, an infection prevention and control inspection had been carried out, and annual fire risk assessments had been conducted.

Leadership, openness and transparency

We saw from minutes that practice meetings were held on a monthly basis. If staff were not able to attend the meetings, the information was cascaded to them by nominated staff members. There were monthly clinical meetings between the GPs and nurse, however these were informal and not documented. Staff told us they had the opportunity to raise issues at the meetings.

The practice managers were responsible for human resource policies and procedures. We were shown the electronic employee handbook that was available to all staff, and included sections on equality and harassment at work. The practice had a whistleblowing policy, and additional details on whistleblowing were available to all staff in the employee handbook. Staff we spoke with knew where to find these policies if required.

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

The practice gathered feedback from patients through patient surveys. The practice reviewed the results and developed an action plan to address specific areas highlighted by patients. For example, staff training and improvements to the telephone system were made in response to patient feedback on the ability to get through to the practice by phone and the satisfaction with phoning the doctor for advice.

The practice had a small patient participation group (PPG) which consisted of four members. Two members were identified as patient representatives and provided feedback to the practice at least every two months. We spoke to one patient representative who told us the practice listened and was responsive and transparent in their actions. They told us that changes were made quickly in response to their feedback. For example, the practice had undergone some refurbishment to the building, and access to the service had been improved by the introduction of weekend walk-in clinics. Minutes from the last PPG meeting in February 2014 showed that the

Are services well-led?

Good

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

practice and the PPG had created a two-year plan to improve the service. For example, further maintenance of the building, and the development of a phlebotomy clinic and alternative therapy sessions.

Staff told us they could provide feedback to the management team during practice meetings or on a one-to-one basis.

Management lead through learning and improvement

We looked at staff files and saw regular appraisals, which included a personal development plan, took place annually. Staff told us that the practice supported them to maintain their professional development through training and mentoring. For example, one of the administrators wanted to develop their management skills and the practice managers had supported him with this by providing one-to-one training and supervision in relevant areas.

The practice had completed reviews of complaints and significant events, and these had been shared with staff during practice meetings to ensure the practice improved outcomes for patients in a timely manner.