Shepherds Bush Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Shepherds Bush Medical Centre, a GP service located in the London Borough of Hammersmith and Fulham. This is the only location operated by this provider.

We undertook a planned, comprehensive inspection on 1 October 2014. During our inspection visit which took place over one day, we spoke with two GPs, the practice nurse, the practice manager, the medical secretary, the administrator and two receptionists. We also spoke with 9 patients and received 27 completed Care Quality Commission (CQC) comment cards.

We liaised with Hammersmith and Fulham Clinical Commissioning Group (CCG), NHS England and Healthwatch.

Shepherds Bush Medical Centre provided a caring service. Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice. However improvements were needed to ensure the practice was also safe, effective, responsive and well-led.

The practice is rated as requires improvement. Our key findings are as follows:

- Staff demonstrated a clear understanding of the issues relating to safeguarding vulnerable adults and children.
- The practice was clean and there were suitable infection control arrangements to reduce the risk of cross infection.
- The GPs attended monthly network meetings to share good practice and discuss local patient needs.
- The practice had numerous ways of identifying patients who need addition support, and were proactive in offering this.
- GPs showed a sensitive and caring approach towards supporting patients, their family and carers with bereavement.

Summary of findings

- Vulnerable patients were offered double appointments.
- Patients praised the practice on its ability to provide appointments at short notice.

Areas of practice where the provider needs to make improvements are as follows:

Importantly, the provider must:

- All staff must receive training relevant to their job role. Regulation 23 (1) (a)
- The practice must demonstrate that they can respond appropriately to medical emergencies. Regulation 9 (2)
- The practice must develop a formal procedure to respond to national patient safety alerts. Regulation 9 (1) (B) (i) (ii) (iii)
- The practice must ensure accurate stock control records are in place for the management of medicines. Regulation 13
- The practice must demonstrate how learning from significant events and clinical audits have influenced practice and improved patient outcomes. Regulation 10 (1) (a) (b) (2) (c)
- The practice must regularly seek the views of patients and those acting on their behalf to enable them to come to an informed view of the standard of care and treatment provided. Regulation 10 (2) (e)

In addition the provider should:

- The chaperone policy should provide more detail.
- The practice should introduce an on-line appointment booking system.
- The practice should ensure the clinical audit cycle is completed.
- The provider should introduce a back-up checking system to ensure that treatment recommendations and prescription changes made in hospital discharge letters have been responded to.
- The practice should establish a patient participation group (PPG) to support quality monitoring.
- The practice should include timescales for dealing with complaints in the complaints leaflet.
- The practice should improve access and information sharing through the introduction of a website.
- The practice should consider giving more time to staff personal development.
- The practice should formalise plans for the future of the practice.

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?

Inadequate

The practice is rated as inadequate for safe as there were areas where improvements must be made.

The practice meeting minutes evidenced that safeguarding concerns were a standing agenda item. Staff spoken with demonstrated a clear understanding of the issues and reporting process.

The practice was clean and there were suitable infection control arrangements to reduce the risk of cross infection. All staff had received infection control training in April 2013.

Significant events were recorded but there was a lack of evidence to demonstrate learning from these had been implemented by key staff to prevent reoccurrences.

The practice did not have a formal procedure in place to respond to national patient safety alerts.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

Although vaccines and medicines were checked by the practice nurse when they were received at the practice, there were no stock records held.

The chaperone policy lacked sufficient detail to enable an untrained chaperone to fulfil this role adequately. Staff who were expected to act as a chaperone had not received any formal chaperone training.

Training records demonstrated that staff had last received basic life support training in March 2013. The practice did not hold a defibrillator at the practice for the treatment of cardiac arrest. Although we were told that a risk assessment had been undertaken this had not been formalised.

The practice undertook appropriate fire drills. Training records demonstrated that staff had not received annual fire safety training in line with their policy.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective as there were areas where improvements must be made.

Summary of findings

GPs attended monthly network meetings; these consisted of GPs and practice managers from 11 practices within the local Clinical Commissioning Group (CCG) to share good practice and discuss local patient needs.

The practice had a system for completing clinical audit cycles. Although these clinical audits had been undertaken, the GPs were unable to demonstrate how these had resulted in an action plan for improvement of the practice or patient care.

There was limited evidence that the practice was proactive in providing relevant training courses for staff including those which were considered mandatory. Staff were not up to date with their annual infection control, fire safety and basic life support training as detailed in the practices policy documents.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering this.

Are services caring?

Good

The practice is rated as good for caring.

The national patient survey data showed patients were satisfied with the practice with 80% of patients rating it as good or very good.

Patients confirmed consent was always sought by clinical staff before undertaking a physical examination or treatment.

Staff spoke to patients in a considerate and respectful manner. Staff were careful to follow the practices confidentiality policy. Although staff said a private space could be made available to patients who wished to have a private discussion, patients we spoke with were not aware this was an option.

GPs showed a sensitive and caring approach towards supporting patients, their family and carers with bereavement.

Vulnerable patients were offered double appointments to enable more time for explanation of conditions and treatment options. Care plans were drawn up and care arrangements were discussed at regular multi-disciplinary meetings.

Translation services were available to those patients whose first language was not English.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for responsive as there were areas where improvements must be made.

Summary of findings

There were a variety of appointments options available to patients including six same day appointments. Patients praised the practice on its ability to provide appointments at short notice.

Although patients were satisfied with the service they received, access and information sharing could be improved with the introduction of a website.

The practice did not have a patient participation group (PPG). There were a number of negative comments on the NHS Choices website which we discussed this with the practice manager. The practice manager said they had not been aware that they could respond to these but would do so in the future as a means to improve patient satisfaction.

Although the practice complaints procedure included information on the timescales for the acknowledgement, investigation and outcome of complaints, this information was not included in the complaints leaflet available to patients.

The electronic system notified staff of those patients known to be vulnerable to ensure staff were aware of any issues.

The layout of the reception area made confidentiality difficult. Staff told us that private space was available, but there was no notice in reception to inform patients of this and patients we spoke with said they were not aware of this facility.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led as there were areas where improvements must be made.

The practice was family orientated and staff said they strove to retain an ethos of a family practice whilst incorporating modern treatments and ways of working. Although the practice had discussed the future there were no formal arrangements in place.

Although staff were clear about their roles and responsibilities and were kept informed of issues affecting the practice through regular meetings, leadership focused on day to day issues.

Staff had not received their mandatory training and there was no proactive support with long term personal development.

The practice had a clinical governance policy, which included patient involvement and experience but there was no patient participation group (PPG) in place.

The practice had a system in place for completing clinical audit cycles but they were unable to demonstrate how these had resulted in an action for improvement.

Summary of findings

The practice had not effectively monitored the service it provided, identified the changes needed or planned for future demands on the 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

Requires improvement

The practice is rated as inadequate for safe. The safe domain effects all population groups therefore the practice is rated as requires improvement for older patients.

The practice was responsive to older people's needs and had adapted their appointment system to accommodate this patient group.

Patients had a named GP and could request a home visit. Care plans had been developed and there was evidence of collaborative working.

People with long term conditions

Requires improvement

The practice is rated as inadequate for safe. The safe domain effects all population groups therefore the practice is rated as requires improvement for the care of people with long term conditions.

Patients with long term conditions were appropriately referred for specialist care and regular multidisciplinary meetings were held.

Patients identified as having chronic conditions such as Asthma, Diabetes and Chronic Obstructive Pulmonary Disease (COPD) were offered annual reviews.

Families, children and young people

Requires improvement

The practice is rated as inadequate for safe. The safe domain effects all population groups therefore the practice is rated as requires improvement for the care of families children and young people.

The practice provided open access to appointments for children.

Data for the take up of immunisation for babies, showed the practice was above average compared to other practices within the local Clinical Commissioning Group (CCG). Staff said six week post natal checks were offered to mothers and babies and non-attenders were followed up by the practice nurse.

A children at risk register was maintained and GPs took part in multidisciplinary case management meetings. GPs had direct access to a Paediatric Consultant via a local hospital.

Clinical staff said children and young people were treated in an age appropriate way, recognised as individuals and had their preferences considered.

Summary of findings

Although clinical staff offered opportunistic sexual health promotion for teenagers, there was no specific health promotion in place for teenagers.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as inadequate for safe. The safe domain effects all population groups therefore the practice is rated as requires improvement for the working-age people (including those recently retired and students).

The practice patient age profile is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group.

Although the practice offered extended opening hours for appointments on a Saturday morning, there was no online appointment booking system.

Health promotion advice was offered but limited accessible health promotion material was available through the practice.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as inadequate for safe. The safe domain effects all population groups therefore the practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable but improvements could be made.

The practice held a register of patients living in vulnerable circumstances such as those with a learning disability and patients subject to domestic violence. The practice had begun to carry out an annual review for those people with learning disabilities.

Double appointments were offered to patients considered vulnerable to enable more time for explanation of conditions and treatment options.

The practice worked with multi-disciplinary teams in the case management of vulnerable people.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Although staff said people who were homeless or travellers could register with the practice this was not actively promoted with any homeless agencies or places where homeless people or travellers may present.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as inadequate for safe. The safe domain effects all population groups therefore the practice is rated as requires improvement for the population group of people experiencing poor mental health (including people with dementia) but improvements could be made.

Patients experiencing poor mental health were offered annual reviews. Where appropriate patients had open access to appointments and where needed double appointments were booked.

Home visits could be arranged and the practice worked regularly with multi-disciplinary teams such as Community Psychiatric Nurses and Social Services. Advanced care planning for patients with dementia and dementia assessments for those patients identified as 'at risk' from memory concerns had been introduced.

Clinical staff had received training on how to recognise signs indicating poor mental health.

The practice told us that patients experiencing poor mental health were given information leaflets and sign-posted to support groups or third sector organisations such as MIND.

Summary of findings

What people who use the service say

We received 27 completed Care Quality Commission (CQC) comment cards and spoke to nine patients on the day of our visit. Most patients were positive about the service they received.

Patients confirmed consent was always sought by clinical staff before undertaking a physical examination or treatment and all consultations and treatments were carried out in the privacy of a consulting or treatment room.

Patients felt the repeat prescription process worked well.

The most recent data available for the practice regarding patient satisfaction was the national patient survey published on 03 July 2014. This showed the practice had scored 59% for patients feeling involved in making decisions about their own care and 67% of patients felt the GP was good at explaining their treatment and results. Although both these results were below the clinical commissioning group (CCG) regional average most patients we spoke with and those who completed comment cards felt they were given sufficient information by the doctor or nurse in an accessible format regarding their condition. Patients also felt involved in making a choice about their treatment options and some patients said the GP gave them printed information from the internet regarding their condition and/or treatment.

Areas for improvement

Action the service MUST take to improve

All staff must receive training relevant to their job role.

The practice must demonstrate that they can respond appropriately to medical emergencies.

The practice must develop a formal procedure to respond to national patient safety alerts.

The practice must ensure accurate stock control records are in place for the management of medicines.

The practice must demonstrate how learning from significant events have influenced practice and improved patient outcomes.

The practice must regularly seek the views of patients and those acting on their behalf to enable them to come to an informed view of the standard of care and treatment provided.

Action the service SHOULD take to improve

The chaperone policy should provide more detail.

The practice should introduce an on-line appointment booking system.

The practice should ensure the clinical audit cycle is completed.

The provider should introduce a back-up checking system to ensure that treatment recommendations and prescription changes made in hospital discharge letters have been responded to.

The practice should establish a patient participation group (PPG).

The practice should include timescales for complaints in the complaints leaflet.

The practice should improve access and information sharing through the introduction of a website.

The practice should consider giving more time to staff personal development.

The practice should formalise plans for the future of the practice.

Shepherds Bush Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP Advisor and an expert by experience who were granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Shepherds Bush Medical Centre

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

Shepherds Bush Medical Centre is a single location practice which provides primary medical services through a General Medical Services (GMS) contract to approximately 3,100 patients in the Shepherds Bush area of West London. The patient population groups served by the practice include a cross-section of socio-economic and ethnic groups. Staff said the majority of patients registered with the practice were from an Asian, Afro-Caribbean or East European background. There is a transient patient population of approximately 30 patients joining and leaving the practice each month. A large number of patients are between the ages of 20 and 35 years.

The practice team was made up of a two (male) GP partnership, a practice nurse (female), a practice manager, a medical secretary, an administrator and three part time receptionists.

Shepherds Bush Medical Centre is not a training practice.

Surgery opening hours are 9.00am – 1:00pm and 3:00pm – 6:30pm Monday to Friday (9:00am – 1:00pm Thursday). Extended hours operate between 10:00am – 12:00noon Saturday.

GP appointments are available between 9:30am – 12:00noon and 4:30 – 6:30 Monday to Friday (9:30am – 12:00noon Thursday). Extended hours operate between10:00 – 12:00noon Saturday.

Shepherds Bush Medical Centre does not provide an out-of-hours service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We liaised with the West London Clinical Commissioning Group (CCG), NHS England and Healthwatch.

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

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

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

We carried out an announced visit on 01 October 2014. During our visit we spoke with nine patients, observed how people were being cared for and reviewed personal care or treatment records of patients. We spoke with a range of staff; two GPs, a practice nurse, the practice manager, the medical secretary, the administrator and two receptionists.

We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We also requested additional information which was reviewed both before during and after the visit. This information included policies and procedures, audits, staff records and minutes from meetings.

Inadequate

Are services safe?

Our findings

Safe Track Record

The practice had appropriate policies and procedures such as safeguarding adults and children, whistleblowing, health and safety, infection control and dealing with significant events. All had recently been reviewed, were electronically stored and were accessible to all staff. Staff we spoke with demonstrated a clear understanding of how and to whom they should report any concerns. We spoke with nine patients on the day of our inspection and received 27 completed Care Quality Commission (CQC) comment cards. All patients said they felt the two GPs and the nurse were knowledgeable and they felt they received safe care.

Staff we spoke with told us that requests for an appointment by the elderly, children or those considered vulnerable would always be facilitated by a GP or the nurse on the day requested.

Learning and improvement from safety incidents

Accident and incident management procedures were in place. Staff were aware of how to record and report accidents and incidents.

The practice also had a major accident response plan in place, which included disaster planning for building problems which affected the day to day delivery of the service, outbreaks such as flu or measles and a major incident.

The practice had a system in place for reporting, recording and monitoring significant events. We looked at the record of significant events and found these were clearly recorded and contained sufficient detail to demonstrate the action taken and learning points to prevent future occurrence. However, when we spoke with the practice manager they were unable to evidence that the actions we had seen recorded on the action plan to prevent re-occurrence, had all been implemented by the relevant staff.

The practice manager told us that where a national patient safety alert related to medicines, a pharmacist from the local CCG medicines management team would contact the GPs and run off a list of affected patients. They would also contact the patient to explain the situation and where appropriate write a new prescription. There was no formal procedure in place to respond to patient safety alerts although the practice manager said they were in the process of developing this.

Reliable safety systems and processes including safeguarding

The practice used an electronic computer programme which staff felt supported them in their day to day work, in particular enabling alerts to be added to a patient's record.

Administrative systems were in place to ensure GPs were given information regarding patient care and treatment such as hospital discharge summaries and test results in a timely manner.

The practice had a detailed safeguarding children's policy and procedure in place, however a lot of the information it contained was general safeguarding information and not practice specific. The main GP partner had been allocated as the safeguarding lead for the practice. All staff spoken with were aware of who this person was, had an understanding of the indicators of abuse and who to report their concerns to. Anyone new to the practice however would receive guidance notes rather than a clear procedure of who to contact and report a concern or allegation of abuse to.

The practice maintained a children at risk register. Clinical staff said they would set up an electronic alert for each child known to be at risk, this also acted as a safeguard on the rare occasions that a locum GP was used by the practice. Staff were aware of multi-agency working.

The safeguarding children policy stated that training was mandatory for all staff each year. Training records evidenced that one administrative staff member had not completed their annual child safeguarding refresher training. Clinical staff had completed Level 3 training and all other non-clinical staff Level 1.

The practice meeting minutes demonstrated that child protection was a standing agenda item.

The practice had a safeguarding vulnerable adult's policy and procedure in place but there was no named safeguarding adults lead. The policy did not make it clear who was responsible for contacting who and confused the reporting of an allegation of abuse experienced personally, with the role of staff should they witness, suspect or be informed of an allegation of abuse. Training records

demonstrated that all but one member of staff had undertaken training, however this had been identified by the practice as a priority to rectify. All staff we spoke with demonstrated an appropriate understanding of what to be aware of and the need to report any concerns to a GP. We were told that vulnerable adults had an electronic alert attached to their records to ensure clinical staff were made aware of and reminded of any concerns when they attended appointments.

Clinical staff had access to mental capacity assessment guidance, including a checklist and best interest's information. All clinical staff demonstrated a clear understanding of Gillick competencies (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had a comprehensive whistleblowing policy but not all staff we spoke with were aware of it or understood the purpose of whistleblowing and the legal protection the Public Interest Disclosure Act 1998 offered staff that raised concerns.

The practice had a chaperone policy and staff were aware that a patient could bring or request a chaperone. Although the policy guided clinical staff in the use of a chaperone and included consent and recording, it lacked sufficient detail to enable a chaperone to fulfil their role fully. The policy did not include; the need for the chaperone to be DBS checked or the need for the examination or procedure to be witnessed and there was no training offered to enable the chaperone to know what a normal clinical examination should look like. We were told that the nurse, administrative staff and receptionists could act as a chaperone. Not all staff who acted as a chaperone understood the need to witness the examination and none had received any formal training in line with General Medical Council (GMC) guidance. Although the policy stated that the chaperone policy was advertised through patient information leaflets, we could find no such reference.

Medicines Management

The practice had an up to date medicines management policy in place. Appropriate arrangements were in place to ensure the cold chain was maintained for the storage of immunizations and travel vaccines. The practice nurse showed us evidence that the refrigerator temperature had been checked on a daily basis to ensure it remained within acceptable limits and that the vaccines were safe to use.

Although vaccines and medicines were checked by the practice nurse when they were received at the practice, there were no stock records held. The practice nurse told us that they would only be able to give an approximate amount of immunisations, vaccines or medicine in stock should there be a burglary at the practice where these were taken.

Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance. We saw a copy of an up to date set of directions and evidence that the nurse had received appropriate training to administer vaccines.

Processes were in place to check medicines and vaccines were suitable for use. All the medicines and vaccines we checked were within their expiry dates. Expired and unwanted medicines and vaccines were disposed of in line with waste regulations.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was no protocol in place for the management of high risk medicines such as warfarin and methotrexate.

Staff told us that when a medicine was due a review this would be flagged up by the electronic system and a repeat prescription could not be generated until this had been undertaken. The system would also alert the prescriber to medicines which were not compatible with each other if prescribed together. The practice had a 48 hour turn

around for repeat prescription requests and patients told us they felt this worked well. We noted that the NHS Choices website was in need of updating as this showed the practice as being able to provide online prescriptions.

Cleanliness & Infection Control

On the day of our visit the practice was clean and hand cleansing gel was available for use throughout the practice. Patients commented that the practice was always clean and tidy.

The practice had an external cleaning contract in place and although an associated risk assessment was in place this was dated May 2013 and was due for review. Staff stated that they did not undertake cleaning and did not have access to cleaning materials, however there were spillage packs available to them to minimise the risk of cross infection and contamination from bodily products.

The cleaning contract included a schedule of tasks and a detailed breakdown of each task to be undertaken. We also saw monitoring records which had been undertaken by the external contractor to assess cleaning standards and set actions to address any concerns.

Staff said they had been offered or had received a hepatitis B immunization, a record of this was held on each staff member's personal file.

The practice nurse was the allocated infection control lead for the practice. An annual infection control audit had been undertaken by the practice nurse and practice manager in July 2014, in line with The Health and Social Care Act 2008 Code of Practice on prevention and control of infections and related guidance. Areas identified as in need of improvement included the replacement of some furniture, the washing of curtains and the de-cluttering of work surfaces. The audit included the action needed to resolve the problem, who was responsible, planned achievement date and date of completion. We noted that all identified problems had been resolved within the planned timescale.

Training records demonstrated that all staff had last received infection control training in April 2013.

On the day of our visit clinical waste was correctly stored and a contract was seen to be in place for the collection and disposal of this. Sharps bins were available in clinical areas.

An up to date legionella (a germ found in the environment which can contaminate water systems in buildings)management, testing and investigation policy was available for inspection. The practice had completed a risk assessment on 22 September 2014 which recorded that no risks had been identified.

The practice meeting minutes demonstrated that infection control was a standing agenda item.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date of September 2014. A schedule of testing was in place. We saw evidence of the calibration and general testing of relevant equipment; for example weighing scales, the fridge thermometer, pulse oximeter, spirometer, nebuliser and the blood pressure monitor.

Staffing & Recruitment

The practice had a recruitment policy and procedure which covered most areas but needed to be reviewed to ensure all areas of safe recruitment were covered. For example, a full employment history with start and finish dates and reasons for leaving, verification of references and certificates of training and or qualifications. We noted that the practice did not use an employment application form which although not a legal requirement, would enable them to ensure most of the necessary pre-employment checks had been undertaken before staff began work.

Staff employment records seen demonstrated that all staff had a contract of employment including terms and conditions, a criminal records check via the Disclosure and Barring Service and proof of registration with the professional body where appropriate.

There was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

meet patients' needs. Although there was no written policy we told by the practice manager that the GPs covered for the nurse and each other. The GPs said they tried not to take annual at the same time and where possible limited this to one week.

Although there was no female GP at the practice we were told by staff and patients that this was not a concern. Staff said that female patients who required intimate examinations and did not want to see a male GP were directed to the local primary care gynaecology department or family planning clinic.

There was an induction process in place which included an introduction to the practice, employment terms and conditions, health and safety related policies and procedures and role specific training. Although we were told that locums were rarely used the practice had developed a locum induction sheet and a one page protocol to inform locums of their referral and prescribing practices.

Monitoring Safety & Responding to Risk

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

We were shown the infection control, health and safety and fire risk assessments which had been completed in 2014. These identified possible risks, set actions to reduce risks and target dates for review.

We saw that any risks were discussed at practice meetings, for example the practice nurse had shared the recent findings from an infection control audit with the team in April and May 2014.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, end of life care plans had been introduced which included quarterly reviews with the palliative care team.

Non-clinical staff were provided with a safety alert button which alerted other staff via the computer system that help was needed. A lone working policy was in place however staff said they rarely worked alone. Staff had not received any formal training in lone working but understood how to minimise any potential risks of physical violence and ensure their own safety in the work place.

Maintenance records showed equipment had been serviced regularly and was in working order.

A Control of Substances Hazardous to Health (COSHH) risk assessment was in place, but this was dated 06 November 2002 and had not been fully completed. A list of cleaning items used at the practice had been recorded and included the items physical and chemical properties, dispose considerations and immediate first aid or fire fighting measures. The practice manager confirmed that all cleaning in the practice was undertaken by an external contract cleaner who had received appropriate COSHH training.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency medical equipment was available including a pulse oximeter, spirometer, nebuliser and access to oxygen. Processes were in place to check emergency equipment was correctly calibrated and emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date. The practice did not retain a defibrillator for the treatment of cardiac arrest. Clinical staff stated that they did not feel this was necessary due to the proximity of the local accident and emergency department. Although we were told that a risk assessment had been undertaken this had not been formalised.

Although some medical emergency equipment was available for staff use, they had not received their annual basic life support training. Training records demonstrated that all staff had last received training in basic life support on 18 March 2013.

Emergency equipment and medicines were held in a secure area of the practice and all staff knew of their location.

An emergency preparedness plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included an outbreak such as flu or measles, problems with the

premises and major incident. The document contained actions to manage the risk but insufficient contact details for example the telephone number for Health Protection Agency (HPA) in the event of an outbreak.

The practice had a fire safety policy and procedure for the protection of staff and patients. This was last updated in January 2014 but did not cover all eventualities for example how staff should respond if a fire was discovered on the first or second floor of the building. The practice health and safety policy stated that all staff should receive annual fire safety training however, records showed that all staff had last received fire safety training on 11 April 2013.

A fire risk assessment had been completed in October 2013 which included action points to minimise risk. There was a designated fire marshal who confirmed they had received fire training and demonstrated sufficient knowledge and understanding of the practice procedure. The fire marshal told us they were responsible for organising and monitoring two fire drills a year. We saw that the practice meeting minutes dated 28 May 2014 recorded that a fire drill had taken place.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff told us that clinical meetings took place monthly. Staff said they used clinical meetings to discuss the latest National Institute for Health and Care Excellence (NICE) guidance. Clinical meeting minutes evidenced the sharing of clinical guidance and best practice. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

GPs told us that they attended monthly network meetings; these consisted of GPs and practice managers from 11 practices within the local Clinical Commissioning Group (CCG) to share good practice and discuss local patient needs. Agenda items from the August 2014 meeting included the changes to a local accident and emergency provision, the introduction of a screening programme for abdominal aortic aneurysm to support with the identification of this condition in older patients and annual health checks for patients with a learning disability.

Monthly multi-disciplinary meetings were held with other healthcare professionals; these included community nurses, health visitors, community psychiatric nurses and palliative care nurses.

Patients identified as having chronic conditions such as Asthma, Diabetes and Chronic Obstructive Pulmonary Disease (COPD) were offered annual reviews and those with complex needs were referred to "the Virtual Ward" operated through NHS Hammersmith and Fulham for assessment and high risk patients were seen by the community matron.

The practice manager showed us benchmarking data they had used for the prescribing of antibiotics. This showed that the practice had over prescribed antibiotics compared to other practices within their networking group. Clinical meeting minutes showed that the practice had discussed their performance against the network plan and QIPP (quality innovation productivity prevention) achievement indicators.

The administrator for the practice was responsible for ensuring patient test results had been received. These results were then scanned to the electronic system and 'read coded' (standard clinical terminology system used in general practice in the UK to record the everyday care of a patient) before being passed to a GP.

The administrator and practice manager were responsible for the electronic scanning and read coding of hospital discharge letters. The GPs said that they or the practice nurse responded to discharge summaries within 48 hours and where appropriate they sent an electronic task alert to the receptionist who would contact the patient to arrange an appointment.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this
decision-making.

Management, monitoring and improving outcomes for people

GPs told us that they attended multidisciplinary meetings with the community palliative care nurses, tissue viability nurses, community matrons and district nurses every two to three months to identify and plan care and treatment for those patients in receipt of end of life care. Joint home visits were arranged where appropriate for those patients in need palliative care and the GPs said they used an online tool (provided through a local hospital) which documented the wishes of patients in receipt of end of life care.

The clinical meeting minutes evidenced that the GPs had introduced dementia assessments for those patients identified as at risk with memory concerns. GP's told us that they had access to a consultant on the older person's assessment team at a local hospital.

The practice manager was responsible for the collation of data for the quality and outcomes framework (QOF). The QOF is a national group of indicators, against which a practice score points according to their level of achievement in the four domains of clinical, organisation,

Requires improvement

Are services effective?

(for example, treatment is effective)

patient experience and additional services. The clinical meeting minutes demonstrated that QOF targets and achievements had been discussed. At this meeting clinical staff had agreed which areas they would take responsibility for to improve results.

The practice had a system in place for completing clinical audit cycles. We were told that clinical audits had been undertaken in the last 12 months for cancer, asthma and COPD (Chronic Obstructive Pulmonary Disease). Although these clinical audits had been undertaken the audit cycle had not been completed and the GPs were unable to demonstrate how these audits had resulted in an action plan for improvement of the practice or patient care.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. All staff were aware of the system and said significant events were discussed on the day they occurred where appropriate and at practice meetings. Although significant events were recorded and discussed there was a lack of evidence to demonstrate that learning from these had been implemented by key staff to prevent re-occurrences.

Effective staffing

The staff team was made up of medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that although staff had attended mandatory courses identified by the practice as essential for their role, they were not up to date with their annual infection control and basic life support training as detailed in the practices policy documents. Records demonstrated that all staff had last attended Cardiopulmonary Resuscitation (CPR) training on 18 March 2013 and infection control training on 11 April 2013.

All GPs were up to date with their yearly continuing professional development requirements and both had been revalidated or had a future date for revalidation (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified role specific learning needs from which action plans were documented. Staff interviews confirmed that they had attended most mandatory training identified as part of the appraisal process, but there was limited evidence that the practice was proactive in providing relevant training courses for staff beyond that which was considered mandatory.

We looked at the future goals identified in staff appraisals and found that some administrative staff felt they had insufficient time for personal development due to work load. We were also told that the practice manager had been in post for over seven years and had only recently been offered and signed up to a role specific professional qualification.

The practice nurse had defined duties they were expected to perform. They were able to demonstrate they were trained to fulfil these duties, for example, administration of vaccines, cervical cytology, infection control and wound care.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complicated cases. Blood results, X-ray results, hospital discharge letters and information from out of hour's providers and the 111 service were received electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP who reviewed these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice attended multidisciplinary team meetings every month to discuss the needs of complex patients e.g. those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning was documented on a shared care plan. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was

a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, however patients did not have access to the Choose and Book system (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) as the practice had stopped using this more than 12 months ago. Staff reported that not having access to the Choose and Book system did not restrict patient choice as clinical staff still gave patients information and a choice about the secondary care services available to them.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. All staff were trained on the system and although they commented positively about the system they were gaining confidence in its use, it was still relatively new and some staff had requested further training.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia care needs were supported to make decisions through the use of care plans. We were told by staff that although those patients with a learning disability had a care plan in place, there had been only one review undertaken for one patient during the last quarter.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic medication reviews for patients with poor mental health and offering smoking cessation advice to smokers.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering this. For example, the practice kept a register of all patients with learning disabilities and had begun to offer an annual health check. The practice had also identified the smoking status of 94.6% of patients over the age of 16 and actively offered nurse led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 1.8% above national figures. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 22.8% below other practices in the CCG. The practice was however 16.1% above other practices for child health surveillance, 6.6% for contraception services and 12.9% for maternity services.

We were told that the practice nurse ran a clinic for chlamydia screening. Although the practice did not have any specific health promotions for teenagers clinical staff said they promoted sexual health as opportunities arose. Know sex workers could be referred to a local Genito-Urinary (GU) clinic or to a dedicated sex worker clinic for additional support and treatment.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with

Requires improvement

Are services effective?

(for example, treatment is effective)

current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

The practice offered varying services to registered patients according to their needs, for example older people over the age of 75 had a named GP. The practice held a register of patients who were identified as being at high risk of admission or in need of end of life care and a care plan was in place for those patients. The GPs worked jointly with district nurses, tissue viability nurses and palliative care nurses to deliver appropriate care and treatment. Those patients identified as in need of end of life care had a care plan which was reviewed every three months and GPs used an on-line end of life tool provided by the local hospital which documented the wishes of the patient in end of end of life care.

GP's attended monthly multidisciplinary case management meetings for patients with long term conditions and had a named contact at the local hospital where they could discuss complicated cases. Patients identified as having chronic conditions such as Asthma, Diabetes and Chronic Obstructive Pulmonary Disease (COPD) were offered annual reviews.

The practice offered a pre-natal vaccine programme and checks of maternal and baby health. Mothers were also offered a six week check post natal which covered maternal health, mental health, social problems or difficulties and baby related issues. A children at risk register was maintained at the practice and GPs took part in multidisciplinary case management meetings as and when needed. GPs had direct access to a paediatric consultant via a local hospital.

Working age people could attend appointments on a Saturday and had access to telephone consultations. GPs said they undertook opportunistic health checks and staff sent patients text message reminders for appointments and information regarding special services such as flu clinics.

The practice held a register of those patients whose circumstances made them vulnerable such as those with a learning disability. Patients with a learning disability had a care plan and the GPs had begun to offer annual reviews and had introduced dementia assessments for those patients identified as 'at risk' from memory concerns.

Patients experiencing poor mental health were offered annual reviews. Staff were aware that these patients had open access to appointments and where needed double appointments were booked or home visits were arranged. GPs undertook multi agency working with Community Psychiatric Nurses and Social Services.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the results from the most recent National patient survey published July 2014 regarding patient satisfaction. Data showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. 80% of patients rated the practice as good or very good, which was above the local clinical commissioning group (CCG) regional average. The practice also scored above the regional average for patients waiting 15 minutes or less after their appointment time to be seen and who usually got to see or speak to their preferred GP.

Patients completed Care Quality Commission (CQC) comment cards to provide us with feedback about the practice. We received 27 completed cards, 92% of these were positive with patients saying staff were efficient, helpful and caring. 48% of patients rated the service they received as excellent or very good and said staff treated them with dignity and respect. Only two comments were less positive regarding the manner of a particular staff member and building access. We also spoke with nine patients on the day of our inspection. All patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. However the open plan reception area made this challenging and some patients felt confidentiality was an issue as other patients could hear or be overheard talking to reception staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

We were told by staff that patients whose circumstances made them more vulnerable such as homeless people, those with poor mental health or those with a learning disability could register and access the practice without fear of stigma or prejudice. Staff told us that people with a learning disability or known mental health problem would be offered a double appointment.

Patients we spoke with and the 27 completed CQC comment cards we received showed that most patients were happy with the service they received. Patients were mostly positive about the care they received. They said the practice nurse and GPs were knowledgeable and caring and reception staff were helpful and friendly.

Care planning and involvement in decisions about care and treatment

We reviewed the results from the most recent National GP patient survey published July 2014 regarding patient involvement in decisions about care and treatment. This showed the practice had scored 59% for patients feeling involved in making decisions about their own care and 67% of patients felt the GP was good at explaining their treatment and results. Although both these results were below the Clinical Commissioning Group (CCG) regional average most patients we spoke with and those who completed comment cards, felt they were given sufficient information by the doctor or nurse in an accessible format regarding their condition. Patients also felt involved in making a choice about their treatment options and some patients said the GP gave them printed information from the internet regarding their condition and or treatment.

The practice also scored below the regional average on the National Patient Survey for recommending the surgery to someone new to the area.

The Quality Outcomes Framework (QOF) figures for the Shepherds Bush Medical Centre identified that the practice had completed 56.1% of their expected target for cervical screening. The absence of a female GP does limit patient choice and could be a contributing factor to the low take-up of cervical screening for the practice. However, staff we spoke with did not feel the lack of a female GP limited patient care as the female practice nurse was qualified for and carried out cervical screening. In addition, we were

told that there were other local services available which patients were signposted to. None of the 27 comment cards we received or those female patients we spoke with raised access to a female GP as a concern.

Staff told us that translation services were available for patients who did not have English as a first language.

The GP's told us that older patients over the age of 75 had a named GP and open access to appointments and where appropriate a care plan. Care plans included information about end of life care and GPs said they met with palliative care nurses each month to review a patient's care. In addition, GP's told us they used an on-line end of life tool which documented the wishes of the patient in end of end of life care.

The GPs said patients with long term conditions such as those with a learning disability and poor mental health also had a care plan and annual review. GPs said they discussed and sought advice for complex cases with a consultant at the local hospital.

Clinical staff said children and young people were treated in an age appropriate way, recognised as individuals and had their preferences considered. The practice consent policy supported this through the statement that teenagers who were 16 and 17 years of age were entitled to consent to their own treatment and this consent could not be overruled by their parent and or legal guardian.

A consent policy was in place and staff confirmed that consent was recorded on patient notes. We were told by clinical staff that consent was always sought before undertaking a physical examination or treatment. Any doubts regarding a patient's ability to understand or give consent were discussed where appropriate with a parent or carer.

Staff said patients came from a variety of backgrounds, a large number being Asian, Afro-Caribbean and Eastern European. We were told that the staff team spoke a variety of languages and where needed the NHS language line was used.

Patient/carer support to cope emotionally with care and treatment

Staff spoke with patients in a considerate and respectful manner. We noted that although the reception and patient waiting area offered limited privacy, reception staff were mindful of this. We were told that a private space could be made available to patients should they wish to have a private discussion with staff. Patients we spoke with were not aware of this and there was no notice in reception.

Staff said vulnerable patients were supported to cope emotionally with care and treatment by being offered double appointments to enable more time for explanation of conditions and treatment options. Vulnerable patients were also given open access to appointments with their named GP to ensure consistency.

Care plans were drawn up and care arrangements were discussed at regular multi-disciplinary meetings. Patient and carer concerns could also be addressed at these meetings.

The practice offered some support with bereavement on a case by case basis. The GPs worked with palliative care nurses to provide appropriate treatment and care. The GP's said they would meet with patients, carers and family before and after bereavement and showed a sensitive and caring approach. Practice meeting minutes evidenced that bereavement and end of life care support was discussed.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

There was evidence to demonstrate that discharge letters from hospitals regarding prescription changes and treatment recommendations had been responded to by GPs in a timely fashion. Although there was no written policy regarding discharge summaries, staff were aware of their roles and responsibilities and assured us that all discharge summaries were responded to by the practice nurse or a GP within 48 hours of receipt.

The surgery had a diverse patient population, with a large group of Punjabi and Polish speakers. We were told that staff spoke most of the languages needed by patients and that there was a translation service via the NHS language line which could be accessed as required. We were told that patients often brought a family member to assist with translation, though this had confidentiality implications which staff showed an awareness of.

We spoke with staff about vulnerable patient groups and what measures the practice had taken to engage with these groups and ensure that services were accessible. We were told that the practice was signed up to the learning disability directed enhanced service (DES) to provide an annual health check for people with a learning disability to improve their health outcomes through the introduction of a health action plan. Although care plans had been introduced for this patient group, only one review for one patient had been undertaken since the had been introduced. Staff told us that the GP's would always make time to see a vulnerable patient. An electronic flag was attached to a patients file to indicate to reception staff when a patient should be given a priority appointment or offered an extended appointment.

Home visits were arranged for those patients who were housebound, terminally ill or too ill to attend the practice. Clinical meeting minutes and electronic patient records evidenced that six monthly reviews had been undertaken for 45 per cent of housebound patients. GPs said that they undertook two or three home visits and up to five telephone consultations a day.

The practice did not use their own patient surveys to actively seek patient feedback. However there was a patient suggestion box in the reception area which staff said had led to better disabled access and a baby changing facility. Although there was no established patient participation group (PPG) to inform and shape the development of the practice, staff were aware of the importance of establishing one and had advertised for volunteers to come forward.

The practice was part of an 11 practice working group which met monthly to discuss local health needs.

The practice worked closely with other healthcare professionals, such as diabetic health services, hospital staff and community teams. Patients were referred to specialist teams outside of the practice as required. The practice had an evolving but robust end of life joint working policy which involved meeting every two to three months to discuss patient care and undertake joint visits with palliative care nurses, tissue viability nurses, community matrons and district nurses. The practice also used an online end of life tool to document the wishes of patients in need of end of life care.

Tackling inequity and promoting equality

We were told by all staff we spoke with that there was open access for children and vulnerable adults such as those with a mental health problem, learning disability, and older patients over the age of 75. Where appropriate older patients had a named GP for consistency.

The practice held an electronic register of vulnerable patients, for example people with a learning disability and victims of domestic violence. These patients were identified on the electronic system when they attend the practice to remind staff of their vulnerabilities.

We were told by the doctor that homeless people were able to register with the practice, however this was not actively promoted with any homeless agencies or places where homeless people may frequent.

Staff told us that the majority of patients were from an Asian, African or Eastern European background. The staff group reflected this diversity.

Although we were told that a number of languages were spoken amongst the staff team, there was very little written practice information available in an alternative language to English other than that provided nationally by the NHS.

We noted that there was limited access to the treatment room used by the practice nurse and one of the GPs. This was due to narrow stairs and no lift. Staff assured us that a

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

ground floor treatment room would be made available when needed, though this system still had its limitations. A ground floor disabled toilet and baby change facility was available and the main entrance to the practice has a powered access push plate. A parking space was available for a mobility scooter.

Access to the service

The practice did not have a website, so all appointments had to be booked over the phone or in person. Staff understood the importance of establishing a website to increase patient access, particularly to those patients who worked. There were a variety of appointment options available to patients such as telephone consultations, home visits, and Saturday appointments for working people who found it difficult to access the practice during usual hours. The surgery had six same day appointments available, and patients praised the practice on their ability to provide appointments at short notice. We were told that the appointments system had changed in November 2013 in response to patient comments regarding increasing access, however patients could not book an appointment on line.

Staff told us that they had recently clarified patient out of hour's information and repeat prescriptions were now issued within 48 hours. Patients commented that they felt that the repeat prescription arrangements were very good.

The atmosphere at reception was relaxed and welcoming, though the layout of the reception area made confidentiality difficult. Staff told us that private space was available, but there was no notice in reception to inform patients of this and patients we spoke with said they were not aware of this facility.

Staff said new patients were given a practice leaflet which detailed the services available at the practice. However this leaflet was out of date and in need of review.

Younger patients were encouraged to put appointment reminders on their mobile phones.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Staff said all complaints were passed to the practice manager or to a GP in their absence. The complaints procedure stated that acknowledgement of a compliant would be made in writing within three working days and resolved within six months.

The complaints leaflet available to patients contained information on how to make a complaint, but did not give timescales for the acknowledgement, investigation and outcome of a complaint. There was a notice in the reception area regarding complaints and staff we spoke with explained that they try to resolve complaints at the time they were raised to prevent them from escalating. Although there was a notice on how to make a complaint in the reception area, very few patients we spoke with said they knew how to make a complaint.

We saw a suggestions box at reception, though the practice manager stated that it was rarely used. The practice manager said that this box was for complaints as well as suggestions, but this was not obvious to patients as it was only labelled as a suggestions box.

We looked at the records of complaints. There were 2 recorded complaints for the year 1st April 2013 to 31st March 2014. Both complaints were dated June 2013 and had been dealt with appropriately. The practice manager informed us that they had not received any complaints since June 2013.

We noted that there were a number of negative comments on the NHS Choices website. We discussed this with the practice manager who said they had not been aware that they could respond to these comments. The practice manager said they would ensure they replied to future comments in order to resolve issues and improve patient satisfaction.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

We discussed the vision and future plans for the practice with the practice manager and GPs. The practice has no written vision or strategy, but staff were aware of the need to address changes. For example planning for the retirement of the practice nurse who had been in post for many years and to have a robust and practical succession plan and strategy for the future to address changes in the patient demographics.

The practice manager had not undertaken any training specific to their role, and had learnt 'on the job'. We were told that essential management training had now been put in place to equip them with the knowledge and skills needed for the role.

Governance Arrangements

The practice had a clinical governance policy, which included patient involvement and experience. This policy stated that patient involvement would be supported and promoted through the use of the patient participation group (PPG). The practice did not have a patient participation group in place, though we were told that this was being addressed.

The practice had a system in place for completing clinical audit cycles. We were told that clinical audits had been undertaken in the last 12 months for cancer, asthma and COPD (Chronic Obstructive Pulmonary Disease). The clinical governance policy included taking appropriate action as a result of clinical audits. Although these clinical audits had been undertaken, the GPs were unable to demonstrate how these had resulted in an action plan for improvement of the practice or patient care.

Policies and procedures identified lines of responsibility. Staff were aware of who to report to and their line of accountability. Although there were some monitoring processes in place the practice was unable to demonstrate how learning from monitoring was used to improve patient safety and the overall quality of the service offered. For example, we followed through on a significant event which showed that a change in policy was required. Staff were unable to evidence that this had been followed through with the appropriate change to practice.

The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. We looked at these policies and procedures most had been reviewed annually and were up to date.

The practice held monthly practice and clinical meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. Although QOF data was discussed at monthly practice and clinical meetings the practice could not demonstrate how this information had been used to improve patient outcomes and influence the future development of the practice.

The practice had basic risk assessments in place, relating for example to health and safety and infection control. These detailed lines of responsibility and actions to minimise identified risks. The health and safety policy specified that all staff should receive annual fire safety training however, the staff training matrix evidenced that staff had last attended fire safety training in April 2013.

Leadership, openness and transparency

The GPs and the practice manager formed the leadership team within the practice. Staff told us that they felt the culture of the practice was one of openness and transparency and felt supported in their roles. However the leadership team reacted to day to day issues and was not proactive in supporting staff with personal development and preparing for the future. For example the practice manager had been in post for seven years and had only recently been enabled to undertake essential role specific training.

The practice nurse had been in post for over 25 years and took responsibility for many of the clinical roles within the practice. Although the practice nurse was nearing retirement there was no formal succession plan in place. The GPs told us they had understood the implications and the need to formalise plans.

The practice had a named lead for appropriate roles such as infection control and safeguarding. All staff we spoke with were able to identify the appropriate lead person and were clear about their own roles and responsibilities. Staff said they felt valued and supported in their day to day work and knew who to go to in the practice with any concerns.

Are services well-led?

Requires improvement

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

Practice meeting minutes covered current topics affecting the practice. Staff were kept informed of issues affecting the practice and discussed how they should respond to complex issues such as domestic violence and managing difficult patients.

Although clinical meeting minutes evidenced that practice targets such as the quality outcomes framework (QOF) and enhanced services were discussed, there was limited evidence to demonstrate overall forward planning. There was no evidence that any one person was planning for or leading the team in the development of the practice long term.

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

Staff we spoke with were aware of the function of a patient participation group (PPG) (a group of volunteer patients who form a link between the patients and the practice with a view to making a useful contribution to the improvement of existing services and help the practice to develop new services to identify and meet patients' needs). However, despite advertising for volunteers to join this group there was no PPG in place.

The practice had gathered feedback from patients through a suggestion box. Staff told us that as a result of patient suggestions a disabled toilet, baby changing facility and parking for a mobility scooter had been made available. The practice manager said the practice was looking into providing an additional telephone line to increase patient access.

The practice had gathered feedback from staff through regular staff meetings. Staff told us they would raise any concern they had with the practice manager or GP.

The practice had a whistle blowing policy and supporting flowchart which was available electronically to all staff. Although staff were aware of the policy not all staff understood its purpose.

Management lead through learning & improvement

The GPs told us they had undertaken three clinical audits as part of their revalidation and appraisal requirements in the last year. These had been for cancer, asthma and chronic obstructive pulmonary disease (COPD), however these had not all been fully completed and the GPs were unable to give any examples of where practice had changed as a result of these audits.

There was little evidence available to demonstrate that the practice had a system in place to monitor and improve quality beyond the local and national performance data from the quality and outcomes framework (QOF). The practice manager was responsible for gathering QOF data which was discussed at clinical meetings. Meeting minutes for July 2014 demonstrated that the practice had looked at their data for out patient referrals which was part of a direct enhanced service (DES) for four specific conditions; endocrinology, paediatric dermatology, urology and gastroenterology. This was part of a referral reduction plan and showed the practice had met their targets.

The practice used benchmarking (a measurement of the quality of policies, processes and systems, with a comparison with standard measurements, to determine what and where improvements can be made) as a comparison to other practices within the local clinical commissioning group (CCG) to monitor and improve patient care. We were shown benchmarking data for antibiotics and non-steroidal anti-inflammatory drugs (NSA's), this showed an over prescribing of antibiotics. Clinical meeting minutes for May 2014 evidenced that benchmarking data had been discussed and an appropriate action plan had been developed to address the over prescribing of antibiotics.

The practice manager told us that they had not been responsible for or personally completed any audits for 2014. However an end of life care audit had been undertaken in 2013 which had led to care planning for patients, quarterly reviews with the palliative care team and a record made on out of hours (OOH) and accident and emergency (A&E) records.

Clinical and practice meetings were held each monthly to discuss issues and address any concerns. We looked at the minutes for those meetings which identified what the learning had been, who had been responsible and any action points but did not always demonstrate that actions had been followed through.

Significant events were recorded and discussed in practice meetings. The practice manager had completed an annual review of these but there was no evidence that any practical or procedural changes had been implemented to prevent re-occurrence.

Are services well-led?

Requires improvement

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

There was no policy in place regarding managing changes in demand and there was no evidence that the practice had considered or planned how it would meet the needs of the patient's in the long term, particularly when the practice nurse retired.

Clinical staff told us that they were able to maintain their clinical professional development through training and educational events.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 23 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers.** • Staff had not received appropriate training and personal development to enable them to deliver care and treatment to patients safely. **Regulation 23 (1) (a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users.** • The practice must ensure patients are protected against the risks of receiving care or treatment that is inappropriate or unsafe. • A procedure must be in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the treatment of a patient. **Regulation 9 (1) (B) (i) (ii) (iii) (2)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of medicines.** • The practice must ensure accurate recording of medicines held at the practice. **Regulation 13**

Regulated activity	Regulation
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Compliance actions

Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

- The practice must protect patients and others who may be at risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable regular assessment and monitoring of the services provided, and where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect them to be aware of.

Regulation 10 (1) (a) (b) (2) (c) (e)