Dr Risiyur Nagarajan

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Dr Risiyur Nagarajan, also known as Dr R. K. Nagarajan, provides primary medical services to people living in Westminster, Brent, Harrow, Ealing, Hammersmith, Hounslow and Barnet. Dr Nagarajan, the principal GP at the practice works with two GP associates. At the time of our inspection, there were 3,100 patients registered at the practice.

The practice is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures; maternity and midwifery services; and treatment of disease, disorder or injury.

We carried out an announced inspection of the practice on the 20 May 2014. The team, led by a CQC Inspection Manager, included a GP, and an Expert by Experience. As part of the inspection, we spoke with five patients who use the practice, the GPs, practice manager and reception staff. All the patients we spoke with were happy with the treatment and care they received. We observed a good and friendly interaction between patients and the receptionists.

There were mechanisms in place to report and record safety incidents, concerns and allegations of abuse. However, the arrangements for learning from incidents were not effective.

There was some evidence of effective care being provided. However, communications with healthcare professionals that may be critical to patient care were not always recorded. This presents a risk to effective care, as vital information required for appropriate care may be missed.

All the patients were complimentary of the care they received. Receptionists knew most of the patients by name. Some patients reported occasional delays in answering phones and booking appointments.

The practice understood and responded to the needs of most of their patients. The practice was still in the process of establishing a Patient Participation Group (PPG), as a result of which essential patient feedback was limited.

There was a positive, open and caring culture within the practice. Staff were clear on their roles and responsibilities and had a good working relationship. However the practice did not have any documentary evidence of a practice-wide strategic objective to improve quality, and manage risk.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There was limited evidence of learning from significant events. The practice did not have any documentary evidence that defines a significant event, how they will be reviewed and used to learn and improve service.

Although staff were aware of local safeguarding protocols, one staff is yet to attend safeguarding training for vulnerable adults and children.

There were mechanisms in place to report and record safety incidents, concerns and allegations of abuse. The practice had systems in place to monitor quality, manage risks and deal with emergencies.

Are services effective?

The practice engaged with other health and social care providers to co-ordinate care and meet patient's needs. However, communication with healthcare professionals that may be critical to patient care were not always recorded. This presents a risk to effective care, as vital information required for appropriate care may be missed.

National guidelines were used to inform the care and treatment of patients. All the patients we spoke with told us their health needs were met. The practice was adequately staffed and had qualified and competent staff, with the right skills and experience.

Are services caring?

We observed good interactions between practice staff and patients. Receptionists knew most of the patients by name. All the patients were complimentary of the care they received. They said they were treated with dignity and respect. Some patients reported occasional delays in answering phones and booking appointments.

Are services responsive to people's needs?

The practice understood and responded to the needs of most of their patients. They were particularly sensitive to the needs of patients from minority groups, of which they had a significant number. Patients' reported that their needs were met. However, the practice had not sought feedback from Asian women about access to cervical screening.

Summary of findings

Are services well-led?

The governance arrangements in place did not ensure that communications with other healthcare professionals that may be critical to patient care were always recorded. The practice did not have documentary evidence of a practice-wide strategic objective to improve quality, and manage risk. There was no documentary evidence that defined a significant event, how they would be reviewed and used to learn and improve the service.

The systems in place for dealing with high-risk patients did not identify patients at risk of cancer, in order to provide early intervention.

There was a positive, open and caring culture within this practice. Staff were clear on their roles and responsibilities and had a good working relationship.

The practice was still in the process of establishing a Patient Participation Group (PPG), as a result of which essential patient feedback was limited.

Summary of findings

The six population groups and what we found

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

Older people
The practice had arrangements in place for patients who are aged 75 and over. They were actively involved in a Clinical Commissioning Group (CCG) wide primary and secondary care multi-disciplinary team meetings – Putting Patients First. These meetings often discussed difficult cases of patients with multiple and complex needs, including people aged 75 and over. The practice had links with several relevant agencies providing appropriate services to patients in this population group.

People with long-term conditions
The practice met the needs of patients with long-term conditions. Patients with long term conditions were identified and targeted for health checks and health promotions. Arrangements were in place with local chemists to deliver medication to housebound patients.

Mothers, babies, children and young people
The practice had arrangements in place for mothers, babies, children and young patients. They worked with other agencies to ensure early recognition and prevention of adverse health for people within this population group.

The working-age population and those recently retired
The practice had arrangements in place to meet the needs of working age people. There were provisions for extended surgery until 8pm every Monday evening. Telephone triage was provided for those patients who were unable to attend the practice.

Patients who are recently retired had access to all services and were encouraged to have regular health checks.

People in vulnerable circumstances who may have poor access to primary care
The practice had arrangements in place for patients in vulnerable circumstances. These included patients who misuse alcohol, patients who require accommodation and patients who are victims of domestic abuse. They use their monthly practice meetings to review, identify and invite some of these patients for health checks and health promotion advice. Other patients were referred to community and hospital services as appropriate.

Summary of findings

People experiencing poor mental health
The practice had arrangements in place for patients experiencing poor mental health. There was a multi-agency approach to the management of mental health. These included early intervention and crisis management.

Summary of findings

What people who use the service say

We spoke with five patients on the day of the inspection and they were all complimentary about the care they received. They said they were treated with dignity and respect and we observed receptionists interacting with patients in a caring manner either over the phone or face to face. Our observation was consistent with the GP survey (2013) results, which found that receptionists were very helpful. The practice score for this measure was 'better than expected', compared to other practices nationally.

Many of the patients have been with the practice for a long time. One patient told us that three generations in her family used the practice (her grandmother, mother and children). They were happy with every aspect of care provided by the practice.

None of the patients we spoke with had any complaints about the practice. One of the patients told us that the practice helped them liaise with a hospital before and after admission and arranged for out-of-hours visits. Another patient said the practice offered them over 50s health checks and that they were very happy with every aspect care they receive.

All the patients we spoke with said staff involved them in decisions about their care.

Areas for improvement

Action the service MUST take to improve

- Communications with other healthcare professionals that may be critical to patient care were not always recorded. This presents a risk to effective care, as vital information required for appropriate care may be missed.
- There was limited evidence of learning from significant events. The practice did not have any documentary evidence that defines a significant event, how they will be reviewed and used to learn and improve service.
- The practice nurse had not attended safeguarding training, and training on how to carry out cervical smears, despite a clear need for this service.
- Mechanisms to encourage patient feedback were underdeveloped at this practice. The patient participation group (PPG) at this practice was being developed.
- The practice did not have a programme of clinical audits.

Action the service COULD take to improve

- The practice could seek feedback from women about access to cervical screening.

Good practice

Our inspection team highlighted the following areas of good practice:

The Practice had a pod where patients can sit with touchscreen display to measure their blood pressure, height, weight, past history, and receive lifestyle information. All this is automatically put in patient's computer record. This is frequently used for new patient health checks and those with long-term conditions. Patients can use the space unsupervised or be supervised by practice staff on request.

Dr. Nagarajan is a member of the executive committee of "Zero to Four" Paddington. This group meets quarterly to review domestic violence, immunisation uptake, language difficulties for all population of Paddington and Queen's Park.

Dr Risiyur Nagarajan

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspection Manager and a GP, and the team included an Expert by Experience. All members of the team were granted the same authority to enter and inspect this practice.

Background to Dr Risiyur Nagarajan

Dr Risiyur Nagarajan provides primary medical services to people living in Westminster, Brent, Harrow, Ealing, Hammersmith, Hounslow and Barnet. The practice is situated in a Health Centre on Dart Street owned by Central London Community Healthcare NHS Trust (CLCH). There were two other GP practices located in the centre.

The practice is located within the City of Westminster. The 2010 Indices of deprivation showed that the City of Westminster was the 75th most deprived local authority (out of 326 local authorities, with the 1st being the most deprived). It has a far higher proportion of 20-39 year old people than other boroughs and 33.2% of the population belong to non-white minorities (England average 12.3%). Arabian people constitute the largest ethnic group (7.2%), with other Asian people accounting for 4.6% of the population, and African people 4.2%.

The principle cause of premature death in the practice's catchment area is cancer followed by cardiovascular disease (which includes heart disease and stroke). A significant number of people also die from chronic obstructive pulmonary disease (COPD).

At the time of our inspection the practice had 3,100 patients on their list. Many of the patients were from Bangladeshi, Portuguese, Somali and various other African backgrounds.

Dr Nagarajan, the principal GP at this practice works with two associates (GPs). There were eight staff employed at the practice at the time of our inspection. The rest of the staff group were made up of a practice manager, a practice nurse, two receptionists and one administrative staff.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people

Detailed findings

- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before our inspection, we reviewed a range of information we hold about the practice. We met with the local area team of NHS England, NHS West London Clinical Commissioning Group and Healthwatch Central West London and reviewed the information they gave to us.

These information included: General Practice Outcomes Standards (GPOS) and General Practice High Level Indicators (GPHLI), which compare practices in England against sets of indicators.

We carried out an announced inspection on 20 May 2014. During our inspection we spoke with a range of staff including: GPs, practice manager, practice nurse and receptionists. We also spoke with five patients who used the practice. We observed the interaction between receptionists and patients and reviewed policies and computer records held by the practices.

Are services safe?

Summary of findings

There was limited evidence of learning from significant events. The practice did not have any documentary evidence that defines a significant event, how they will be reviewed and used to learn and improve service.

Although staff were aware of local safeguarding protocols, one staff is yet to attend safeguarding training for vulnerable adults and children.

There were mechanisms in place to report and record safety incidents, concerns and allegations of abuse. The practice had systems in place to monitor quality, manage risks and deal with emergencies.

Our findings

Safe patient care

There were appropriate systems in place to protect people from the risk of infection and risks associated with medicines. Staff were aware of key risks to patients and were able to describe their role in the reporting risks. None of the five patients we spoke with had any concern about safety.

Learning from incidents

There were mechanisms in place to report and record safety incidents, concerns and allegations of abuse. However, the management of significant events requires improvement.

The practice used an IT system to report incidents and the practice manager and reception staff described the system for reporting and investigating incidents. We saw an example of a patient who had become verbally aggressive and threatening to staff and patients. The police were involved. We saw documentary evidence of the review of this incident, which explored potential safety issues for patients in the waiting area. Learning points were shared with staff.

We spoke to the practice manager and a GP about the management of significant events. There was a shared understanding of what constitutes a significant event. However, the practice did not have any documentary evidence that defines a significant event, how they will be reviewed and used to learn and improve service. There was limited evidence of learning from significant events. There were only two serious events recorded for 2013/14, and there was no evidence of learning from these.

Safeguarding

There were systems in place to keep patients safe from the risk of abuse. The practice had written policy documents in every room with the relevant list of contact details for named safeguarding offices in the local area. They had safeguarding procedures for both adult and children. Staff understood the safeguarding procedures and knew how to identify potential signs of abuse when dealing with vulnerable adults and children. Dr. Nagarajan is the practice safeguarding officer. The doctors and staff in the practice were appropriately trained, with the exception of the practice nurse. The doctors were trained to Level 3 and

Are services safe?

the staff where trained to Level 2. Although the practice nurse understood the safeguarding procedure, we did not see any evidence of safeguarding training completed by them.

Monitoring safety and responding to risk

The practice had a system that ranked patients on the basis of risk, which allowed for a targeted approach to care. For example, patients with complex needs who had recently been discharged from hospital were proactively invited for consultation on receipt of their discharge summary. Patients assessed as high-risk were discussed at monthly practice meetings.

Monday mornings were usually busy, and the practice manager helped the receptionists manage long queues when they arise. The practice manager also told us they increased consultation sessions last year (2013) in direct response to patients' concerns about long waits.

Medicines management

The practice had systems, processes and practices in place to manage medicines safely. Vaccines were stored securely in a locked fridge in the nurse's treatment room and the key was kept securely elsewhere. The details of all injections were recorded on the practice's computer system; including consent obtained, batch number and expiry date.

All the vaccines and vaccines in the fridge were in date. The fridge temperature had been recorded daily with details of the temperature ranges (lowest to highest). The practice nurse told us that if fridge failed or if the temperature was outside the recommended range the nurse would tell the practice manager who would seek advice from the CCG pharmacist. If in doubt, the practice manager would destroy affected stock and borrow from the other practices in the building to maintain continuity of service. Prescription pads were kept locked in Dr. Nagarajan's surgery and distributed by the practice manager. The practice did not keep any stock of controlled drugs.

There were a number of ways patients could obtain repeat prescription; in person, by telephone, fax or letter. The practice policy was to have repeat prescriptions ready within 48 hours of request. If a patient ran out of a critical medicine the practice would supply on demand. Repeat prescriptions were usually for three months. High-risk medicines and antidepressants were only available on one month repeats. Appropriate arrangements were in place to ensure that patients who were prescribed depot antipsychotic medicines were overseen by a GP rather than the practice nurse.

Cleanliness and infection control

The building was well maintained, in good state of repair, and clean.

Central London Community Healthcare NHS Trust (CLCH) was responsible for the management of infection control within the health centre. This included the management of clinical wastes and sharps. The needle stick protocol was displayed in all clinical areas and the practice had a full range of specific waste and sharp bins. The waste and sharp bins were collected and disposed weekly by contractors employed by CLCH. The practice offered a similar service (clinical waste disposal) for patient-held sharps bins. The provider kept copies of weekly clinical waste collection.

Cleaning was also contracted out by CLCH. The communal areas of the practice were cleaned daily. A deep clean (with everything removed from all surfaces) was carried out every six months.

There were hand washing signs and instructions in all toilets, with soap and paper towels. Alcohol hand wash was available on request.

CLCH had a programme of infection control audits. CLCH inspectors carried out checks and infection control audits across all the three practices in the health centre. We saw evidence of health and safety checks and audits carried out by CLCH, this included: Portable Appliance Test (PAT); fire alarm and extinguisher checks.

Staffing and recruitment

The practice employed a total of eight clinical and non-clinical staff. These were made up of three GPs; a practice manager; a practice nurse, two receptionists and one administrator. Most staff had worked at the practice for over 10 years. Recruitment checks had been carried out prior to employment.

We looked at the files of some of the staff, including the most recently appointed. All staff had proper contracts and current Disclosure and Barring Service (DBS) reference had been obtained as required.

Are services safe?

Dealing with Emergencies

The practice had systems in place to deal with and respond to emergencies. They had a Business Continuity Management Policy dated March 2014. The policy set out plans for how services would continue in the event of an adverse incident.

All staff had had annual Cardiopulmonary resuscitation (CPR) training. Staff were able to describe the procedure to follow in the event of an emergency. First aid kits were also available in the reception area. A named first aider for the building was clearly stated on the first aid notice.

Equipment

Up-to-date equipment was available. A defibrillator and the emergency bag were located in the reception area and contained the appropriate equipment. We saw written log of weekly checks of the security alarm system by CLCH. The last check was carried out a day before our inspection (19 May 2014).

All instruments and equipment were calibrated and properly maintained under a practice contract with an external company. These included: blood pressure machines, spirometer, fridge, and carbon monoxide monitor. The last check on the equipment was carried out in March 2014.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice engaged with other health and social care providers to co-ordinate care and meet patient's needs. However, communication with healthcare professionals that may be critical to patient care were not always recorded. This presents a risk to effective care, as vital information required for appropriate care may be missed.

National guidelines were used to inform the care and treatment of patients. All the patients we spoke with told us their health needs were met. The practice was adequately staffed and had qualified and competent staff, with the right skills and experience.

Our findings

Promoting best practice

National guidelines were used to inform the care and treatment of patients. We spoke with two of the GPs in the practice and saw evidence of how they used national guidelines. For example, the GPs used the British National Formulary (BNF) guidelines in the selection and clinical use of medicines. They also used guidelines from National Institute for Health and Care Excellence (NICE), and their local CCG, which were available online.

We saw documentary evidence of GPs attendance at monthly local Clinical Learning Sets (CLS) and educational meetings at Edgware Community Hospital where appropriate guidelines were discussed.

NICE guidelines were used to inform the care of patients with long-term conditions. There were no formal clinics for them. Their care was managed through normal booked consultations.

The GPs told us they paid attention to patients and ensured they understood procedures, treatments and referrals. We saw evidence of consent being sought and given. The feedback we received from patients was consistent with what the GPs told us.

Data we reviewed prior to our inspection indicated that the practice recorded a lower diagnosis of asthma than expected when compared to other practices nationally. The practice was aware of this and has included Asthma in their health promotion campaign.

Management, monitoring and improving outcomes for people

The practice used the monthly CLS meetings to benchmark their performance against other practices locally. In addition to this, there were monthly practice meetings between GPs, the practice manager, and practice staff. Patients care and treatment were discussed at these meetings. We reviewed minutes of these meetings and found no evidence of actions being taken to address problems identified. We discussed this issue during our feedback session.

According to the General Practice High Level Indicators (GPHLI 2013/14), this practice was one of three within NHS West London Clinical Commissioning Group with a low percentage of cervical smears undertaken. The practice

Are services effective?

(for example, treatment is effective)

recorded 55.19% compared to a national average of 72.42% of patients who have had a cervical smear. The GPs told us that this was because all the GPs in the practice are male. The practice provided care to a significant number of patients from Asian communities and many of the females were reluctant to see a male doctor for a cervical smear. Many of these women were directed to a walk-in gynaecology clinic within 10 minutes' walk of the practice. We were told that once the nurse had been adequately trained, they would carry out cervical smears. At the time of our inspection, the uptake for cervical smears was still low and the nurse had not been trained despite working at the practice for 12 months.

The General Practice Outcome Standards (GPOS) showed that the practice was one of the few practices in the catchment area with a zero early detection rate for cancer. When we discussed this with the practice, they were unaware and advised us they would look into the data. This evidence suggests that patients with cancer are not likely to be identified early at this practice.

We were told by one of the GPs that there was a good local provision of Diabetes retinal screening – eye screening programme for diabetic patients. GPHLI 2013/14 data showed that the Diabetes prevalence for this practice was 2.31 compared to a national average of 1.09. The Diabetes Cholesterol monitoring for this practice was 0.67 compared to a national average of 0.83. Therefore, despite the higher prevalence of diabetes within the practice's patient population compared to the national average, fewer numbers of patients had their cholesterol monitored. The GPs told us that this was primarily because a significant number of patients failed to show up for screening.

The practice did not have a programme of clinical audits. However, they had conducted an audit on the inappropriate use of out of hours service. The learning from the audit was used to improve service.

Staffing

The practice was adequately staffed. They had qualified and competent staff, with the right skills and experience. Most of the staff had been working at the practice for many years, which promoted continuity of care.

Each staff had a contract of employment and a job description. The practice manager carried out an annual appraisal for the receptionists and administrative staff. Training and learning needs were discussed and agreed during appraisals. We saw evidence of completed training identified during the previous year's appraisal.

There was no formal written induction process for the newest employee (Practice Nurse), who was employed 12 months prior to our inspection. The practice manager told us their induction included 'sitting in' on sessions with each GP. They were yet to be trained to carry out cervical smears.

There was a staff handbook, which contained policies and procedures which included whistleblowing and data protection policies.

Working with other services

The practice engaged with other health and social care providers to co-ordinate care and meet patient's needs. Systems were in place for transferring and acting on information about patients seen by the Out of Hours Service.

The practice had an informal working arrangement with district nurses and health visitors who were based in the same building. Meetings with district nurses and health visitors tended to be ad hoc. There were instances when concerns about patient care were discussed but not recorded. This presents a risk to effective care, as vital information required for appropriate care may be missed. There was no evidence of any formal joint working arrangements with these health professionals. The practice manager agreed to record these discussions in the future.

Dr Nagarajan attended a monthly CCG wide multidisciplinary group meeting called "Putting patients first". The practice discussed their high risk patients with complex needs at this monthly meeting.

The practice worked with MacMillan nurses and local hospitals to care for their terminally ill patients. Out of Hours service providers were informed of patients in this category. They have an out of hours telephone message directing patients on how to get help in emergencies and life threatening situations. They worked with the intermediate care team at St Charles Hospital to support patients with long-term conditions.

Are services effective?

(for example, treatment is effective)

Dr. Nagarajan is a member of the executive committee of "Zero to Four" Paddington. This group meets quarterly to review domestic violence, immunisation uptake, language difficulties for all population of Paddington and Queen's Park.

Health, promotion and prevention

The practice's approach to health promotion was largely based on opportunistic discussions during consultations. They offered new patients a consultation to determine their past medical history. The GPs provided dietary advice especially to diabetic hypertensive patients.

A section of the practice leaflet, which is given to new patients, gave advice on a range of health issues. This included: smoking, exercise, blood pressure, cervical smears, breast screening, male prostate problems, and immunisation. We saw information of smoking cessation clinics on the notice board.

The practice manager told us the practice actively discouraged patients from smoking by explaining the risk factors associated with this lifestyle. The practice referred patients to "KICK IT Stop Smoking Service" – a smoking cessation service.

The practice also had a designated area where patients could use a touchscreen display to measure their blood pressure, height, weight, past history, and receive lifestyle information. All this was automatically put in patient's computer record. This was frequently used for new patient health checks and those with long-term conditions. Patients could use the space unsupervised or be supervised by practice staff on request.

Are services caring?

Summary of findings

All the patients were complimentary about the care they received. They said they were treated with dignity and respect. Some patients reported occasional delays in answering phones and booking appointments. We observed good interactions between practice staff and patients. Receptionists knew most of the patients by name.

Our findings

Respect, dignity, compassion and empathy

We spoke with five patients at this practice. All the patients were complimentary about the care they received. They said they were treated with dignity and respect, and their privacy was respected. We observed receptionists interacting with patients in a caring manner either over the phone or face to face. Our observation was consistent with the national GP survey (2013) results, which showed that receptionists were very helpful. The practice score for this measure was 'better than expected', compared to other practices nationally.

Many of the patients had been with the practice for many years. One patient told us that three generations in her family use the practice (her grandmother, mother and children). They were happy with every aspect of care provided by the practice.

None of the patients had any complaints about the practice. One of the patients told us that the practice helped them liaise with a hospital before and after admission and arranged for out-of-hours visits. Another patient said the practice offered them over 50s health checks and that they were very happy with the care they had received.

The national GP survey (2013) showed that many of the patients in this practice were happy with their experience of making appointments. The practice was 'tending towards better than average' compared to other practices nationally on this question. However, for waits more than 15 minutes after their appointment time to be seen, the practice score was 'worse than expected' compared to other practices nationally. This was consistent with what one of the five patients said. They said there were occasional delays in answering the phones. Another patient who needed a follow up appointment after being prescribed antibiotics said there were occasional delays in making appointments.

Involvement in decisions and consent

Patients said staff involved them in decisions about their care. We saw evidence on the computer records where consent had been sought and obtained from patients. Staff understood how to seek and obtain consent from patients.

The GP survey results (2013) showed that the practice was 'worse than expected' compared to other practices nationally with regards to GPs explaining tests and

Are services caring?

treatments. We did not see any evidence to corroborate this during our inspection. However, the score for nurses explaining test results was 'tending towards better than average' compared to other practices nationally.

Mechanisms for obtaining patient feedback are limited at this practice. The Patient Participation Group (PPG) was still being developed. There were only three members as at the time of our inspection and they had not started meeting. The practice manager told us they were actively recruiting members to the group. There was an invitation on the notice board for patients to join the PPG.

We also saw information on services being provided by the practice on the notice board. The practice information leaflet had relevant information for patients. This included: opening hours, the surgery team, patients' rights and responsibilities, out of hours advice, home visits, repeat prescriptions and test results.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice understood and responded to the needs of most of their patients. They were particularly sensitive to the needs of patients from minority groups, of which they had a significant number. Patients' reported that their needs were met. However, the practice had not sought feedback from Asian women about access to cervical screening.

Our findings

Responding to and meeting people's needs

The practice understood the different needs of their patient population. The practice manager told us they had 3,100 patients on the practice list. Many of the patients came from Bangladeshi, Portuguese and Somali backgrounds. There were also a sizeable number of patients from various other African backgrounds.

The practice provided interpreter service, which met the language needs of the diverse population. Patients who required social housing were provided with letters in support of their applications and some patients were helped to complete their application for housing. The practice was also aware of ethnic centres like the Somali and Moroccan centres and signposted their patients to the culturally relevant social activities they provide. Many Asian women, who did not want to see a male doctor for cervical smears were directed to a walk-in gynaecology clinic within 10 minutes' walk of the practice. The nurse employed by the practice had not been adequately trained, and could not carry out cervical smears. There was no evidence that the practice had sought feedback from these women about access to cervical screening. The practice had not considered alternative ways to engage with these patients.

The practice liaised with and referred patients to health visitors, district nurses and community matrons, who shared the same building with them. Home visits were sometimes offered to vulnerable people with complex needs. All the patients we spoke with said the practice responded to and meet their needs. Patients with long-term conditions who may need to spend more time with the GP were identified and automatically allocated two 15 minutes appointment slots with the GP.

The practice was located on one level and easily accessible for disabled patients. There were ramps in car park and one disabled toilet.

Access to the service

The appointments system in the practice was easy to use, supported choice and enabled people to access the right care at the right time. Patients could book appointments in advance and in emergency. The practice kept up to 10 appointment slots open for people who may need to see a GP urgently or in an emergency. Telephone consultations were available for patients who may need them,

Are services responsive to people's needs?

(for example, to feedback?)

particularly patients of working age. With the exception of one patient, who said they sometimes find it difficult to book appointments, the majority of patients did not raise concerns about the appointment system. The GP patient survey 2013 also reported that patients' experience of booking appointments was tending towards better than average at this practice compare to other practices nationally.

Concerns and complaints

The practice had a complaints policy, and a process for handling and dealing with concerns. There were no written complaints on record. All the patients we spoke with said they had no reason to complain about the service. We asked the practice manager why there were no complaints recorded. They said they were always proactive in dealing with patient concerns. They told us about growing concerns in 2013 for an increase in consultation slots. This led to an increase in the sessions provided by one of the associate doctors from two sessions per week to three sessions per week.

There were no comments on the NHS Choices' website about the practice.

Are services well-led?

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

Summary of findings

The governance arrangements in place did not ensure that communications with other healthcare professionals that may be critical to patient care were always recorded. The practice did not have documentary evidence of a practice-wide strategic objective to improve quality, and manage risk. There was no documentary evidence that defined a significant event, how they would be reviewed and used to learn and improve the service.

The systems in place for dealing with high-risk patients did not identify patients at risk of cancer, in order to provide early intervention.

There was a positive, open and caring culture within this practice. Staff were clear on their roles and responsibilities and had a good working relationship.

The practice was still in the process of establishing a Patient Participation Group (PPG), as a result of which essential patient feedback was limited.

Our findings

Leadership and culture

Staff were able to articulate the ethos of the practice, which was to provide excellent and compassionate care that is sensitive to patient's needs. However, the practice did not have any documentary evidence of their strategy, vision or values. There was no documentary evidence of any strategic planning, objective setting or prioritisation.

The culture within the practice was sensitive to the needs of patients from different backgrounds. They helped their patients for whom English was not their first language complete forms to access social services. They signposted patients from Moroccan and Somali background to local centres and culturally relevant activities.

Governance arrangements

The governance arrangements in place ensured that every staff were clear of their roles and responsibilities. The practice manager who was the registered manager was in charge of the day to day operation of the practice. Practice meetings were held on a monthly basis. We saw records of practice meetings from July 2013 – May 2014, but actions were not recorded, despite being focused on patient care.

Meetings with district nurses and health visitors tended to be ad hoc. There were instances when concerns about patient care were discussed but not recorded. This presents a risk to effective care, as vital information required for appropriate care may be missed.

Where discussions were documented, for example minutes of practice meetings, actions were not recorded. Subsequent meetings did not record how the issues raised at the previous meeting were addressed or not. There was no evidence that actions were being taken to address issues being identified.

The practice acknowledges the need for formal records.

Systems to monitor and improve quality and improvement

The practice work with Clinical Commissioning Group (CCG) to monitor and improve quality of patient care. Dr Nagarajan attended CCG quarterly and the Clinical Learning Sets (CLS) every month.

Patient experience and involvement

Mechanisms to encourage feedback were underdeveloped at this practice. The patient participation group (PPG) at

Are services well-led?

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

this practice was being developed. There were only three members as at the time of our inspection and they had not started meeting. The practice manager told us they were actively recruiting members to the group.

The practice manager told us they were open to learning and improving care for all their patients but they had very little in place to enable patient provide feedback. They were particularly aiming to recruit young patients to their PPG. We observed that the practice had no internet presence (website). This may limit the opportunity for young patients to engage with the practice.

Staff engagement and involvement

There was evidence of staff involvement and engagement at this practice. There were monthly practice meetings, which were attended by all staff. Staff told us there was an open culture within the practice. They were aware of and are able to raise concerns about any aspect of patient care or staff welfare.

The practice had a whistleblowing policy, which all staff were aware of.

Learning and improvement

With regards to staff, there were systems in place which enabled learning, and improved performance. The practice manager carried out annual performance appraisals of staff. Training needs were identified during these appraisals. We saw evidence of training completed on the basis of 2012/13 appraisals.

There was limited evidence of learning from significant events. Our analysis of QOF data (2013) showed that the practice was much worse than expected with regards to number of significant events recorded. There were only two serious events recorded for 2013/14. The practice did not have any documentary evidence that defines a significant event, how they will be reviewed and used to learn and improve service.

Identification and management of risk

There were systems in place to identify and manage risks relating to the health and safety, fire and infection control. These were managed centrally by CLCH. Risks to business continuity had been identified and mitigated. The practice had a business continuity management policy (15/03/2014).

There were systems in place for dealing with high-risk patients. For example, patients discharged from hospital were proactively invited to see the doctor for consultation and medication review. However, patients with cancer are not likely to be identified early at this practice. The practice was one of the few practices in the catchment area with a zero early detection rate for cancer and they did not know about this, until we told them.

Older people

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

Summary of findings

The practice had arrangements in place for patients who are aged 75 and over. They were actively involved in a Clinical Commissioning Group (CCG) wide primary and secondary care multi-disciplinary team meetings – Putting Patients First. These meetings often discussed difficult cases of patients with multiple and complex needs, including people aged 75 and over. The practice had links with several relevant agencies providing appropriate services to patients in this population group.

Our findings

The practice had good arrangements in place for patients who are aged 75 and over. They were actively involved in a CCG wide primary and secondary care multi-disciplinary team meetings – Putting Patients First. These meetings discussed cases of patients with multiple and complex needs, including people aged 75 and over. GPs developed their knowledge more about how to care for people in this population group from a wide range of professionals.

The practice manager told us that they had about 30 – 40 patients aged 75 and over registered with the practice. The practice offered health checks and home visits to these patients. None of the patients we spoke with were aged 75 and over. However, computer records confirmed that patients in this population group were assessed by GPs and practice nurse, and referred as appropriate.

There were good links between the practice and the care of elderly services based at St Mary's Hospital and Charing Cross Hospital. They also liaised with district nurses and community matrons both based at the same health centre as the practice.

The practice manager told us they liaised with the elderly carers group based at the Beethoven Centre, which was close to the practice. They also worked with 'Robust Rapid Assessment Team' based at 'Health at the Stowe', Harrow Road. They offered urgent access, visits and appropriate support to elderly patients.

People with long term conditions

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

Summary of findings

The practice met the needs of patients with long-term conditions. Patients with long term conditions were identified and targeted for health checks and health promotions. Arrangements were in place with local chemists to deliver medication to housebound patients.

Our findings

The practice met the needs of patients with long-term conditions. A patient (male, 60) with complex and long term conditions, who had been a long term patient at the practice, told us that they were very happy with the treatment and care they receive at the practice. They said the communication and interaction with and from all staff was good.

The practice identified patients with long term conditions and targeted them for health checks and health promotions. Arrangements were in place with local chemists to deliver medication to housebound patients. This included setting up and management of dossett boxes.

Patients in this population group who may need to spend more time with the GP were identified and automatically allocated two 15 minutes appointment slots with the GP.

The practice liaised with and referred patients in this population group to district nurses, community matrons, rapid assessment team, and out of hours team based at St Charles Hospital. The practice plan to start offering annual flu injections to patients with long term conditions.

Mothers, babies, children and young people

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

Summary of findings

The practice had arrangements in place for mothers, babies, children and young patients. They worked with other agencies to ensure early recognition and prevention of adverse health for people within this population group.

Our findings

The practice had arrangements in place for mothers, babies, children and young patients. Antenatal care was provided in the practice for mothers. The practice also provided a range of services for patients in this population group. These included: child development and immunisation clinics, family planning, travel immunisations and advice by appointment.

In addition to these clinics, the practice provided information to patients about a drop-in clinic (for children under five) at Queens Park Health Centre to see a health visitor on Tuesday mornings between 9:30am – 11:30am, and Thursday afternoons between 1:30pm – 3:30pm.

Working age people (and those recently retired)

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

Summary of findings

The practice had arrangements in place to meet the needs of working age people. There were provisions for extended surgery until 8pm every Monday evening. Telephone triage was provided for those patients who were unable to attend the practice.

Patients who are recently retired had access to all services and were encouraged to have regular health checks.

Our findings

The practice met the needs of working age people. There were provisions for extended surgery until 8pm every Monday evening. Telephone triage was provided for those patients who are unable to attend.

Routine Health checks and health promotion was provided to this population group during consultations.

We saw evidence of a letter written to an employer to improve a patient's working conditions at work. The letter explained their physical limitations and the adjustments that were needed in their working environment.

Patients who were recently retired had access to all services and were encouraged to have regular health checks. Health promotion advice was also given to these patients as appropriate. These included: exercise, taking up interests and hobbies, and maintain active lifestyle.

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

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

Summary of findings

The practice had arrangements in place for patients in vulnerable circumstances. These included patients who misuse alcohol, patients who require accommodation and patients who are victims of domestic abuse. They use their monthly practice meetings to review, identify and invite some of these patients for health checks and health promotion advice. Other patients were referred to community and hospital services as appropriate.

Our findings

The practice had arrangements in place for patients in vulnerable circumstances. These included patients who misuse alcohol, patients who require accommodation and patients who are victims of domestic abuse.

The practice, identify and invite some of these patients for health checks and health promotion advice. These were usually done through their monthly practice meetings.

For other patients, the practice liaised with and referred them to local community or hospital based services as appropriate. We saw evidence of referrals to domestic violence unit and drug and alcohol services. Letters were written to local authorities in support of patient's application for accommodation.

People experiencing poor mental health

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

Summary of findings

The practice had arrangements in place for patients experiencing poor mental health. There was a multi-agency approach to the management of mental health. These included early intervention and crisis management.

Our findings

The practice had arrangements in place for patients experiencing poor mental health. They liaised with and referred patients to local community psychiatric services and early intervention teams. These included urgent and routine referrals as necessary.

GPs take the lead in mental health at this practice. They were actively involved in a CCG wide primary and secondary care multi-disciplinary team meetings – Putting Patients First. Cases are presented by local GPs at these meetings for learning and decisions about care and support for patients and carers.

The practice informed patients and carers of, and referred them to relevant and appropriate organisations for support. These included MIND Counselling and Community Psychiatric Nurses.

In exceptional circumstances and where necessary, patients were referred for Consultant Psychiatric assessment.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use the service were not always protected against the risks of inappropriate care and treatment because risks relating to patients health and welfare were not always recorded, assessed and managed. Regulation 10 (1) (b). The systems designed to assess and monitor the quality of the service was not effective. The practice did not have a programme of clinical audits and there was limited evidence of learning from significant events. Regulation 10 (1) (a), 2 (c) (i). The mechanisms designed to regularly seek the views of patients to enable the practice to come to an informed view in relation to standard of care and treatment was underdeveloped and therefore ineffective. Regulation 10 (2) (e). People who use the service were not always protected against the risks of inappropriate care and treatment because risks relating to patients health and welfare were not always recorded, assessed and managed. Regulation 10 (1) (b). The systems designed to assess and monitor the quality of the service was not effective. The practice did not have a programme of clinical audits and there was limited evidence of learning from significant events. Regulation 10 (1) (a), 2 (c) (i).

This section is primarily information for the provider

Compliance actions

The mechanisms designed to regularly seek the views of patients to enable the practice to come to an informed view in relation to standard of care and treatment was underdeveloped and therefore ineffective. Regulation 10 (2) (e)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The practice nurse had not received appropriate training to deliver care and treatment to people who use the service. Regulation 23 (1) (a).