The Foreland Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Foreland Medical Centre on 8 October 2015. Overall the practice is rated as Good.

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.

Our key findings were as follows:

- Staff were clear about reporting incidents, near misses and concerns and there was evidence of communication of lessons learned with staff.
- The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice had several ways of identifying patients who needed additional support, and was pro-active in offering this.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.
- The practice had a clear, patient-centred vision and staff were clear about the vision and their responsibilities in relation to this.
- There was an open culture and staff felt supported in their roles.

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

Importantly, the provider must:

Summary of findings

- Ensure care and treatment is provided in a safe way for patients through the proper and safe management of medicines, in particular in relation to the security of prescriptions.

In addition the provider should:

- Ensure a record is kept of the regular fire drills carried out;
- Install an emergency pull cord in the disabled toilet;
- Ensure that all clinical staff are able to access recall alerts on the practice's computer system for patients on high risk medicines to provide more demonstrable oversight of these patients;
- Ensure the recent DBS checks for the nurse and healthcare assistant carried out in previous employment are updated by the practice's own DBS checks;
- Ensure discussion of informed consent for medical procedures is recorded in the patient's notes in all cases;
- Arrange further development of practice policies to tailor them specifically to the practice and remove references to organisations no longer in existence;
- Consider making a written record of GP partner meetings to document action agreed to drive improvement, and enable follow up and review of progress to be tracked at subsequent meetings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services, as there are areas where improvements are needed.

Risks to patients were assessed and managed. However, no record was kept of regular fire drills carried out and there was no emergency pull cord in the disabled toilet on the day of the inspection to enable people to call for help.

Systems were in place to safely manage medicines. However, prescriptions ready for printing were left in printers in unlocked treatment rooms which could compromise security. There were arrangements in place to support the management of patients on high risk medicines. However, the GP we spoke with about this was unable to readily identify from the practice computer record system which patients were on recall, although administrative staff were able to demonstrate that there were alerts on the system.

There were recruitment policies and procedures in place and there arrangements for pre-employment checks. However, the criminal records (DBS) checks for the nurse and healthcare assistant, although recent, related to their previous employment.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Clinical audits were carried out to demonstrate quality improvement in care and treatment and people's outcomes. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

The practice had a consent protocol which staff were aware of and followed. However, we noted that discussion of informed consent for a procedure had not been recorded in one patient's notes we reviewed.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and

Summary of findings

they were involved in decisions about their care and treatment. There was plenty of supporting information to help patients understand and access the local services available. We also saw that staff treated patients with kindness and respect and maintained confidentiality. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had adequate facilities and was appropriately equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. The practice had listened and responded to patient feedback about access to appointments and had taken action to improve this.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and mission statement. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. However, many policies were model policies obtained from external sources which needed further development to tailor them specifically to the practice and in some cases remove references to organisations no longer in existence. There were governance arrangements in place, including weekly all practice meetings, through which risk and performance monitoring took place and service improvements were identified. However, separate GP partner meetings were informal and not documented. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.Home visits were available for older patients if required.Flu vaccinations were provided to older people in at-risk groups.The practice carried out proactive care planning with a named doctor offering continuity of care to patients over 65 and worked closely with district nurses who case managed patients with complex needs. There was a primary care navigator on site to support vulnerable older patients and facilitate access to a range of services.The practice had monthly multidisciplinary meetings with social workers, mental health workers and district nurses to discuss at risk patients and used a rapid response service to keep people at home avoiding a hospital admission where possible.The practice took a pro-active approach to end of life care and also provided direct bereavement support.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care or those people with the most complex needs. Longer appointments and home visits were available when needed. The practice carried out in-house monitoring of long term conditions such as diabetes, asthma and COPD The practice also offered an in-house phlebotomy and blood pressure monitoring service There were higher than average numbers of patients with HIV/AIDS registered with the practice and there were close links with local HIV/AIDS clinics in managing their treatment. The practice ran an enhanced service for out of hospital services to provide care in the surgery, near to patients' homes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Arrangements were in place to safeguard children from abuse that reflected relevant legislation and local requirements. There were systems in place to identify and follow up children who were at risk, for example, children and young people from travelers' families, immigrant children from areas where female genital mutilation (FGM) was practiced and children in residential homes. Clinical staff worked closely with health visitors to ensure good professional links and regular discussion of at risk children and troubled families. There was joint working with midwives, health

visitors and school nurses who provided antenatal and other children's services from a local health centre, including the provision of a weekly baby clinic. Childhood immunisation rates for the vaccinations given were broadly comparable to CCG rates in 2013/14. The practice offered easy access to advice and appointments for children and appointments were available outside of school hours.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflected the needs for this age group. This included a range of on-site services such as phlebotomy and blood pressure monitoring and psychological therapies for patient convenience and accessibility, and health checks for eligible adults.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, refugees, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability and extended health check appointments for a large and growing refugee population. There were close links with the local learning disabilities service and the practice was forging further links with refugee services to co-ordinate and respond to refugees' health care needs and support.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients in this group were given longer appointments and provided with

continuity of doctor and timely follow up. The practice carried out annual health checks for patients with mental health needs and at the time of our inspection had completed checks for 67% of patients in this group. There was an on-site psychotherapist to whom doctors referred patients who would benefit from counselling, including cognitive behaviour therapy. Patients experiencing anxiety, depression and were also signposted to a CCG support website, 'Take time to talk' which provided a confidential NHS service for people aged 18 and over and facilitated access to therapy. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice carried out screening for the early identification and diagnosis of dementia and referred patients to a local memory clinic and to the on-site primary care navigator to facilitate support needs. Patients experiencing a mental health crisis were assessed urgently at the practice or at home. The practice could also refer patients to a local 24 hour urgent care centre for urgent assessment.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015showed the practice was performing in line with or above local and national averages. There were 88 responses and a response rate of 19%.

- 95% patients said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 73%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.
- 95% of patients said the last appointment they got was convenient compared to the CCG average of 91% and national average of 92%.
- 83% patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 73% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards in which patients all had something positive to say about the service experienced. Many commented on the caring nature of the doctors, the polite attitude of the reception staff and the dignity and respect they were shown. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

We spoke with 10 patients, including two with learning disabilities and two members of the patient participation group (PPG) on the day of our inspection. Their experience aligned with that highlighted in comment cards and they were mostly very satisfied with the care and treatment provided.

The Foreland Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a second CQC inspector and an Expert by Experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to The Foreland Medical Centre

The Foreland Medical Centre is a single location surgery which provides a primary medical service through a General Medical Services (GMS) contract to approximately 4145 patients in the Notting Dale area within the Royal Borough of Kensington and Chelsea, West London.

The population groups served by the practice included a cross-section of socio-economic and ethnic groups, including a large travellers community. For approximately a third of patients their first language is not English. A relatively low proportion of patients (5% of the practice population) were aged over 75. There were also below average numbers of children and young adults cared for at the practice (20% aged up to 18 years). The practice had a higher than average population of working age adults (69%). There are higher than average rates of deprivation within the catchment area compared to CCG and National averages. Twenty one per cent of residents in Notting Dale have a long term limiting illness compared to 12.3% in Kensington and Chelsea and 14.1% in London.

The practice is registered to carry on the following regulated activities: Diagnostic and screening procedures; Maternity and midwifery services; and Treatment of disease, disorder or injury.

At the time of our inspection, there were two whole time equivalent (WTE) GPs comprising two GP partners (one full and one part time) and a long-term locum GP, and practice manager at The Foreland Medical Centre. The practice also employed a full time practice nurse, a part time health care assistant and three WTE administrative staff.

The practice is open 8:00am to 1:00pm and 2:00pm to 6:00pm Monday, Tuesday, Thursday and Friday; and 8:00am to 1:00pm on Wednesday. Appointments are from 9:00am to 12:30pm Monday to Friday and 3:00pm to 6:00pm Monday, Tuesday, Thursday and Friday. An extended hours surgery is offered 6:30pm to 8:30pm Mondays. The practice is closed at 1:00pm Wednesdays. The doctors take telephone consultations between 12:00pm and 12:30 pm each week day. The practice has arrangements with two local practices to provide surgeries at weekends.

There are also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours services are provided by a local provider. Patients are provided with details of the number to call and are advised that staff will take their details and contact the doctor on call, who will then provide advice by phone or a home visit.

Why we carried out this inspection

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

Detailed findings

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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with NHS West London (Kensington and Chelsea, Queen's Park and Paddington) Clinical Commissioning Group (CCG), local Healthwatch and NHS England.

We carried out an announced visit on 8 October 2015. During our visit we spoke with 10 patients and a range of staff including the two GP partners, the practice nurse, healthcare assistant, the practice manager, and reception/ administrative staff. We reviewed 26 comments cards where patients who visited the practice in the week before the inspection gave us their opinion of the services provided. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events and clinical audits. We reviewed personal care plans and patient records and looked at how medicines were recorded and stored.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Non-clinical staff told us they would inform the practice manager in the first instance of any incidents and there was also a recording form available on the practice's computer system which was accessible to all staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, due to a lack of awareness of features within the practice's new computer system the quantity of medicines for a patient was automatically increased on the patient's repeat prescription. Had the error not been spotted the patient could have received an excess of their required medication. This was discussed within the practice and as a result further checking was put in place against the original medication template and the new system instructor was contacted to provide training in disabling the system feature which caused the error.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). Alerts and guidelines were received by email and the practice manager disseminated anything relevant to the practice to all clinical staff. Where appropriate the alert or guidance would be put on the agenda for clinical meetings for discussion and review of any changes in practice required. We saw evidence of this, for example in the minutes of a meeting in August 2015 was an MHRA drug alert was discussed concerning the recall of a pain relief drug due to risk of fungal contamination. The minutes recorded follow up action; although this particular alert did not apply to the practice, it was agreed that the practice would need to disseminate this important information relevant contacts such as local chemists and the CCG. All staff were required to sign the alert to show they had read and were aware of it before action was taken and we saw evidence of this.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies contained a section on who to contact for further guidance if staff had concerns about a patient's welfare but the details had not been added. However, a list of contacts was available in the reception office. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs had Level 3 child protection training, although details of the training completed by the locum GP were not available at the time of the inspection. The practice nurse, healthcare and reception and administrative staff were trained at Level 2.
- A notice was displayed in the waiting room, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and regular fire drills were carried out, although no record was kept of the drills carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw up to date certificates for this. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. However, there was no emergency pull cord in the disabled toilet on the day of the inspection to enable people to call for help.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and

tidy and a cleaning schedule was in place which we saw. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place, although staff had difficulty in identifying the most recent version on the practice computer system. The protocol made reference to a separate needlestick injuries protocol which we were shown. Staff had received up to date training in infection prevention and control. Six-monthly infection control audits were undertaken by the practice nurse and acted upon. There had been no external audits in the last year but action was in hand to arrange this with the local CCG.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescriptions were kept securely in most respects. However, prescriptions ready for printing were left in printers in unlocked treatment rooms which could compromise security. The practice undertook to address this immediately, including a risk assessment of current practice and the implementation of closer monitoring of prescription batch numbers; the practice sent us a copy of the prescription monitoring log introduced immediately after the inspection. There was a process for ensuring that medicines were kept at the required temperatures. We saw that checks of fridge temperatures were carried out daily and recorded. There were arrangements in place to support the management of patients on high risk medicines, including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions. However, the GP we spoke with about this was unable to readily identify from the practice computer record system which patients were on recall, although administrative staff were able to demonstrate that there were alerts were on the system.
- Recruitment checks were carried out and the files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment in the majority of cases. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). However, the DBS checks for the nurse and healthcare assistant, although recent, related to their previous employment.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a system in place for all the different staffing groups to ensure that enough staff were on duty. The practice manager liaised with the GP partners in planning and managing the workforce and took appropriate steps to meet changes in demand. For example, the recent appointment of the healthcare assistant had been made to enable the practice to take on new initiatives such as 'whole systems care' and 'out of hospital services'. There were appropriate arrangements in place with locum agencies if clinical cover was required, including pre-employment checks to ensure the suitability of locums to practice.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice manager was in the process of updating the plan at the time of the inspection and expected to complete this within the next two weeks.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The GPs also attended a monthly local network learning forum and regular meetings with a 'buddy' practice locally where guidelines were discussed and practice reviewed.

The practice had access to a local rapid response team to keep people at home avoiding unplanned hospital admission where possible.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 98% of the total number of points available (9% above the CCG average and 4.5% above the national average), with 1.9% exception reporting across all QOF domains. For 15 of 16 clinical indicators the practice scored the maximum points available, all above the CCG and national average. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013/14 showed;

- Performance for diabetes related indicators was better than the CCG and national average: 99.6% compared to 86.4% and 90.1% respectively;
- The percentage of patients with hypertension having regular blood pressure tests was better than the CCG and national average: 84% compared to 77.2% and 79.2% respectively;
- Performance for mental health related and hypertension indicators was better than the CCG and national average: 91.6% compared to 88.1% and 90.9% respectively; and
- Performance for dementia related indicators was diagnosis rate was better than the CCG and national average: 100% compared to 91.5% and 93.4% respectively.
- Performance for chronic obstructive pulmonary disease (COPD) related indicators was rate was the only QOF outcome worse than the CCG and national average: 85.7% compared to 89.4% and 95.2% respectively.

The ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) reported in Health and Social Care Information Centre (HSCIC), Hospital Episode Statistics (HES), was 0.28 below the national average. This was identified by CQC prior to the inspection as a 'large variation for further enquiry'. We discussed this with the practice who told us there had been some coding data degradation in transferring to a new computer system which could explain the relatively low ratio. They expected the ratio to be higher in the next QOF return based on corrected coding.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. The practice provided evidence of three practice-led clinical audits completed in the last two years, which were completed audits where the improvements made were implemented and monitored. For example, an audit of documented indications and length of treatment of patients receiving dual antiplatelet therapy (to prevent cardiovascular disease) led to the introduction of measures to improve the recording of the reason for and the duration of treatment. This included using the letters received from secondary care with information about treatment to highlight the treatment on patient records, and instructions to ensure doctors also looked for a reason/and duration of treatment in the patient's notes when medicines were being re-authorised as part of their medication review. The practice participated in applicable local audits, such as a CCG audit of primary care mental health service referrals, and A&E and urgent care unplanned admissions.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed members of staff that covered such topics as

the staff handbook and practices policies and procedures, fire safety, health and safety and confidentiality. We saw the completed induction record for the recently recruited healthcare assistant.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months, apart from the recently recruited healthcare assistant.
- All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.)
- Staff received training that included: safeguarding, fire safety, basic life support, infection control, equality and diversity, and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets was also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team (MDT) meetings took place on a monthly basis to consider patients with complex needs, including those with long term conditions and mental health problems who had been assessed as at risk.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. The practice had a consent protocol which made appropriate references to the Mental Capacity Act (MCA) 2005 with regard to mental capacity and "best interest" assessments in relation to consent. There was also a related MCA policy. Staff had received MCA training and understood the relevant consent and decision-making requirements of legislation and guidance regarding consent. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. The consent protocol made provision for documenting consent for specific interventions using a consent form, for example, for any procedure which carried a risk. A note would be made in the medical record detailing the discussion about the consent and the risks. However, we noted that discussion of informed consent for a procedure had not been recorded in one patient's notes we reviewed.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those in at risk groups including patients with HIV, vulnerable children and adults, patients with learning disabilities and mental health problems. Patients were then signposted to the relevant service. For example, obese patients were referred to weight loss and exercise classes and offered access to a dietician if appropriate. The practice nurse provided advice to identified smokers at a smoking cessation clinic.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 77% and the national average of 82%. There was a policy to offer reminders for patients who did not attend for their

Good

Are services effective?

(for example, treatment is effective)

cervical screening test which was managed by the CCG. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 71% to 92% and five year olds from 66% to 85%. These rates were broadly comparable to CCG averages and met the practice's targets apart from the MMR 2 booster which was 6% below the CCG average. Flu vaccination rates for the over 65s were 76% (3% above the CCG average), and at risk groups 49% (3% below the CCG average).

Patients had access to appropriate health assessments and checks carried out by the practice nurse and healthcare assistant. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, by referral to the GPs, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 26 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with 10 patients, including two with learning disabilities and two members of the patient participation group (PPG) on the day of our inspection. Their experience aligned with that highlighted in comment cards and they were mostly very satisfied with the care and treatment provided. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

Results from the national GP patient survey showed patients were broadly happy with how they were treated and that this was with compassion, dignity and respect. The practice scored above CCG and national averages in some areas and below in others for its satisfaction scores on consultations with doctors and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 87% and national average of 92%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 73% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 75% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

The practice pointed out that there had been a relatively low patient response rate to the survey from 86 patients (19% of those invited to participate). The practice had carried out its own survey using the Department of Health GP Assessment Questionnaire (GPAQ). 129 patients responded, and satisfaction scores for consultations were consistently above the benchmark for GP practices who had undertaken a survey using the GPAQ tool.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment but results were in below local and national averages. For example:

- 72% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 74% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.

However, in the practice's own survey patients rated the practice above benchmark scores for involvement in their care planning and decision making. This aligned with the positive views from patients we spoke with we spoke with and those who completed CQC comment cards.

Staff told us that interpreter / translation services were available for patients who did not have English as a first language. When advanced notice was received of the need

Good

Are services caring?

for an interpreter reception staff booked this and arranged a double appointment for the patient. The practice website had a facility to translate the content into a wide range of languages.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice facilitated patient access to a number of support groups and organisations, for example patients with HIV/Aids were referred to the local community HIV/Aids clinics, with which the practice had close links.

The practice identified patients who were carers opportunistically during appointments. However, the practice told us it had identified its support to carers as an area for development. They recognised that a more robust system was required for identifying carers and their support needs, which they were now beginning to put in place with support from an on-site primary care navigator.

Staff told us that if families had suffered bereavement, their usual GP contacted them to offer condolences. This was followed by referral to counselling services and signposting to a charitable bereavement support organisation website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice was participating in the CCG's 'whole systems integrated care project to provide coherent and integrated health and social care services to older adults in West London.

Services were planned and delivered to take into account the needs of different patient groups and to help provide and ensure flexibility, choice and continuity of care. For example:

- The practice offered an extended hours clinic on Monday evening between 6.30pm and 8.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability and other groups such as refugees and patients with mental health problems.
- Home visits were available for older patients / patients who would benefit from these.
- There was a primary care navigator on site to support vulnerable older patients and facilitate access to a range of services.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities and interpreter / translation services available.
- The practice was introducing care plans for patients aged 75 and over and worked closely with district nurses who case managed patients with complex needs.
- The practice ran an enhanced service for out of hospital services to provide care in the surgery, near to patients' homes.
- There was an on-site psychotherapist to whom doctors referred patients who would benefit from counselling, including cognitive behaviour therapy.
- There were higher than average numbers of patients with HIV/AIDS registered with the practice and there were close links established with local HIV/AIDS clinics in managing their treatment.

Access to the service

The practice was open 8:00am to 1:00pm and 2:00pm to 6:00pm Monday, Tuesday, Thursday and Friday; and 8:00am to 1:00pm on Wednesday. Appointments were from 9:00am to 12:30pm Monday to Friday and 3:00pm to 6:00pm Monday, Tuesday, Thursday and Friday. An extended hours surgery was offered 6:30pm to 8:30pm Mondays. The practice was closed at 1:00pm Wednesdays. The practice had arrangements with two local practices to provide surgeries at weekend. Patients could book 'routine appointments' up to four weeks in advance. A limited number of morning appointments could be booked on the day. Urgent appointments could also be booked on the day to see the duty doctor. Doctors provided telephone consultations daily throughout morning surgery between 12:00pm and 12:30pm. Around 40 patients per week were seen between 4:00pm and 5:00pm at a daily walk in clinic for urgent conditions and for vulnerable children and adults. There were online services including appointment booking and prescription ordering.

People we spoke to on the day were mostly complimentary about the appointments system. This aligned with results from the 2014-15 national GP patient survey, which showed that patient's satisfaction with how they could access care and treatment was comparable to or better than local and national averages. For example:

- 95% of patients said the last appointment they got was convenient compared to the CCG average of 91% and national average of 92%.
- 79% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 95% patients said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 73%.
- 83% patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 73% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

Patients we spoke with on the day were able to get appointments when they needed them. We also spoke with two members of the Patient Participation Group (PPG) who also commented favourably on the appointments system. These views aligned with those of patients who completed CQC comments cards, although one patient mentioned that it was sometimes difficult to get through to the practice on the telephone, first thing in the morning.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had also reviewed patient satisfaction with the appointments system in the light of feedback from the PPG patient satisfaction survey conducted in 2013-14. The action plan put in place as a result of the survey included: increasing telephone access to the practice nurse; improved online services; and earlier practice morning opening times. These actions had all been implemented.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. There were additional policies to support staff in the handling of concerns covering whistleblowing, bullying and harassment and equal opportunities.

We saw that information was available to help patients understand the complaints system. Advice was available on a notice board in one of the practice corridors, although not in the main waiting area. However, in response to our feedback the practice provided evidence immediately after the inspection that this had been addressed. There was a complaints leaflet which was made available to patients on request. There was also advice about making a complaint in the practice leaflet made available to all patients and on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint but none had needed to follow the process.

We looked at the information provided by the practice on all complaints received in the last 12 months. We found these were satisfactorily handled, dealt with in a timely way, and showed openness and transparency in dealing with the complaint. Complaints and their outcomes were discussed with appropriate staff and with the practice team to communicate wider lessons learned. We saw meeting minutes where complaints were discussed, for example where the process of allocating urgent appointments and customer service and staff attitudes was reviewed as a result of lessons learnt from a complaint.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a misunderstanding about the cancellation of an appointment when a follow up appointment had arranged a patient complained about the attitude of reception staff in dealing with matter. As a result of reviewing the complaint, steps were taken to improve communication with patients about the cancellation process and ensure closer liaison between reception and GPs when follow up appointments were being made. Staff were also reminded of the need to provide a professional and courteous service at all times.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to 'provide first class care to all our patients'. The practice had a mission statement which had been communicated to and discussed with practice staff. The statement was not on display to patients in the reception area or on the practice's website. However, as a result of our feedback the practice provided evidence immediately after the inspection to show the mission statement was now on display.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the practice's vision and good quality care. This outlined the structures and procedures in place and ensured:

- there was a clear staffing structure and that staff were aware of their own roles and responsibilities;
- a comprehensive understanding of the performance of the practice;
- a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements; and
- there were robust arrangements for identifying, recording and managing risks and issues, and implementing mitigating actions.

The practice had a comprehensive range of policies which were available to all staff. There was a staff handbook containing appropriate human resource policies. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff. Each policy was dated and marked with a review date to enable systematic review and updating. However, many policies were model policies obtained from external sources which needed further development to tailor them specifically to the practice and remove references to organisations no longer in existence such as the former PCT.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing broadly in line with, and in many cases better than, national standards across the majority of indicators. QOF performance was reviewed on an ongoing basis at practice meetings to ensure the quality of patient care was kept under continuous scrutiny and enable improvement action to be taken in targeted areas.

There were weekly 'all practice' meetings, to disseminate relevant information throughout the practice and give staff the opportunity to raise issues. We saw a selection of minutes of these meetings. There were also weekly clinical meetings between the GP partners which were informal and were not documented. However, the practice told us they had identified this as an area for development and recognised there needed to be a more structured approach to clinical meetings.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. They said there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so, and felt supported if they did. Staff said they felt respected, valued and supported in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. We saw there was a white board in the staff room on which all staff were encouraged to put forward issues for discussion at practice meetings.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys, complaints received and the NHS friends and family test. The PPG met on a regular basis and reviewed with the practice the results of patient surveys and agreed action plans for improvements. For example, to meet requests for online services, in migrating to a new clinical computer the

Are services well-led?

Good

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

practice was able to introduce registration for online services, repeat prescriptions, to make/cancel appointments, enable patients to access their own limited medical records and provide patients with their own log ins. The practice had identified as an area for development the need to deal with the difficulty of recruiting members to the PPG. Invitations to join the PPG were on the practice website and in the practice leaflet. There was no information available about the PPG in the practice's patient waiting area but the practice undertook to address this immediately after the inspection.

We noted the feedback from the NHS friends and family test. This showed six patients who had responded to the test in the last month were extremely likely to recommend the practice, three would likely and one would be extremely unlikely to recommend the practice to friends and family.

We discussed with the practice the ratings on the NHS Choices Website, the majority of which were favourable. The practice manager recognised that this was a source of feedback that was not used sufficiently in the practice. Evidence was provided immediately after the inspection that the practice manager had set up a login to enable the practice to respond to postings with a view to taking a more proactive approach in reviewing the feedback received.

The practice also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local new schemes to improve outcomes for patients in the area. For example, the practice was an 'early adopter' of the in the CCG's 'whole systems integrated care project to provide coherent and integrated health and social care services to older adults in West London.

The practice served a large travellers' site in West London and was seeking to engage with this 'difficult to reach' and highly mobile group of patients with a range of complex health support needs. To assist in this the practice had recruited a member to the PPG to act as spokesperson on behalf of the travellers site.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider needs to ensure care and treatment is provided in a safe way for patients through the proper and safe management of medicines, in particular in relation to the security of prescriptions.Regulation 12 (1) and 2(g)