Dr Nader Lewis

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the practice of Dr Nader Lewis (also known as St Marks Medical Centre) on 26 August 2015. Overall the practice is rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice had effective systems in place to manage some risks but procedures in relation to staff recruitment and induction, infection control and medical emergencies required improvement.
- Patients' needs were assessed and care was planned in line with national guidance. We found that care for long-term conditions was being managed in line with guidance but the practice was carrying out little in the way of care planning. The practice had identified the management of diabetes as an area for improvement.
- Patients we spoke with were very positive about the practice and reported being treated with care and respect. They said they were involved in their care and decisions about their treatment. However, the practice tended to score below average in the national GP patient satisfaction survey for questions on care and compassion and patient involvement.
- The practice provided information about its services in the form of a practice leaflet. The practice did not have a website although this was under development. Information about how to complain was available at the practice and easy to understand.
- Patients said they found it easy to make an appointment and they were able to see the same GP regularly. National patient survey scores were better than average for this aspect of care.
- The practice had suitable facilities and was equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff were supported by management. However, while the practice had recruited a patient participation group, it was not yet actively engaging with this group.
- Staff told us they were well supported and had access to the training they needed to develop in their role.

The areas where the provider must make improvements are:

- The practice had migrated to a new electronic patient records system in October 2014. All staff and clinicians working in the practice must be trained to ensure that they are competent at using the system effectively. In the case of clinicians, this includes being able to add relevant 'Read codes', alerts or flags, and be able to make use of 'safety-netting' tools within the system. Clinicians must also be able to complete relevant electronic templates for health checks, advanced decisions and care planning. The practice staff must have the capability to run data reports on the system so as to accurately monitor its performance and patient outcomes.
- The practice must have a supply of oxygen ready for use in an emergency or carry out a risk assessment to show why this is not necessary.
- The practice must ensure that it effectively monitors and manages risks in relation to health and safety, for example by commissioning fire safety and legionella risk assessments and acting on any recommendations.
- Practice procedures in relation to health and safety must be checked, inspected and tested as appropriate, for example by holding periodic fire drills.
- The practice lead for infection control should ensure that the practice infection control policy and procedures meet required standards for primary care and that infection control in the practice is audited annually and that any recommendations are acted on.
- The practice must ensure recruitment arrangements including all necessary employment checks for all staff are undertaken.

In addition the provider should:

- Maintain a stock of emergency medicines that meets with current recommendations for general practice, for example including glucagon and antibiotics for the treatment of suspected meningitis.
- Record any instances of chaperoning in the relevant patient notes.
- Consider making more information about the practice and its services available to patients, for example through a website.
- Explore ways of actively engaging with the patient participation group and practice patients more widely.
- Review information displayed in the waiting and reception area and remove information that is out of date. The practice should consider providing the practice leaflet and complaints leaflet in other languages commonly spoken by practice patients such as Arabic and Polish.
- Introduce an induction programme for new and temporary staff and record staff progress and any assessment of competencies as appropriate.

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.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Incidents were used as a source of learning.
- Although most risks to patient safety were assessed and well managed, there were some gaps, for example the practice could not show us a fire safety risk assessment or a legionella risk assessment. The practice had not carried out any fire drills to test its fire safety response.
- The practice staff were aware of their responsibility to safeguard children and vulnerable adults from the risk of abuse. Practice staff were appropriately trained and knew the procedure to raise concerns.
- The practice was not fully prepared for medical emergencies. The practice was equipped with a defibrillator but did not have emergency oxygen on site and had not carried out a risk assessment to show why this was not necessary. The practice kept a small stock of emergency medicines which were regularly checked. However this stock did not include all of the recommended emergency medicines for general practice.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- The GP principal was up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice was engaging well with local specialist services to provide good quality care to people with enduring mental health problems and substance misuse problems in a primary care setting.
- Data showed that patient outcomes were generally comparable with national averages although uptake of the influenza vaccination in 2013/14 by patients over 65 was relatively low at 60%.

Summary of findings

- The GP principal was able to show us evidence of clinical audit and on-going monitoring of data for example, patient attendances at A&E. However, their ability to review and monitor care was impaired by their limited capacity to use the patient electronic record system.
- The practice worked with other health and social care professionals for example, the district nursing team; palliative care nurse; specialist consultants and attended locality meetings with other GP practices. Record keeping and care planning was limited however.

Are services caring?

Requires improvement 

The practice is rated as requires improvement for providing caring services.

- National survey data consistently showed that patients rated the practice lower than the local and national averages for some aspects of care such as the care and concern showed by the doctor. The practice was unclear for the reasons for this and had not carried out further investigation, for example, with its patient participation group.
- In contrast, patients we spoke with said they were treated with compassion and respect and they were involved in decisions about their care and treatment. Patients we spoke with who had longer-term conditions valued being able to see the same doctor.
- Patient confidentiality and privacy was protected.
- The practice had a policy covering carers and told us they identified patients with caring responsibilities and recognised their needs although this was not evident in the patient records we reviewed during the inspection. Information for carers was displayed in the waiting room but some of this material was out of date.
- The practice supported patients reaching the end of their life and liaised with the palliative care nurse where appropriate. The practice referred patients following bereavement for further support.
- The practice provided information for patients about the service in the form of a practice leaflet. The practice did not yet have its own website although this was under development.

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services.

Summary of findings

- The practice reviewed the needs of its local population and engaged with community and specialist health teams to provide coordinated care. The practice was accessible to patients with disabilities and parents with young children. The practice had a substantial population of Polish patients and had employed a Polish receptionist to facilitate communication.
- The practice generally performed well on indicators of access to the service and this was also reflected in comments made by patients we spoke with. Patients reported their experience of making an appointment as good. The practice was open for extended hours from 7.00am one day a week.
- The practice employed a female GP to provide two clinical sessions per week. The practice also had a female practice nurse.
- 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.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The GP principal and practice manager had a long term strategy for the practice, including future plans for succession and an understanding of business risks and opportunities. This was a small practice with a clear, visible leadership structure.
- The practice had policies and procedures to govern activity. Whilst there were some effective systems in place to assess and monitor risk, there were also some gaps. For example, the practice had not had risk assessments completed for fire safety and legionella. The practice also did not keep comprehensive records of the checks it carried out as part of the recruitment process.
- Staff had received appraisals and attended staff meetings and learning events. Staff told us they felt valued and they felt able to raise any concerns or ideas for improvement. Staff received mandatory training but there was no structured programme of induction for new or temporary staff.
- The practice was aware that it performed comparatively poorly on some indicators of patient feedback but had not explored why this might be the case. The practice had started to establish a patient participation group but this was not active at the time of the inspection.

Summary of findings

- The practice had migrated to a new electronic patient record system in October 2014. This system was not being used effectively and this negatively impacted on the practice's ability to assess and monitor the quality of its care.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people.

Nationally reported data showed that outcomes for patients for conditions commonly found in older people were generally in line with national guidelines.

- Longer appointments and home visits were available for older people when needed. The practice was able to provide continuity of care to older patients and carers. Patients told us this was something they valued about the practice.
- The practice told us they identified carers and provided patients who were carers with information about available support and relevant services. However, there was little evidence of this in the electronic patient records we reviewed. The practice had an information board for carers displayed in the waiting room but some of this information was out of date.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions.

- In 2014/15 the practice was generally performing in line with the national average for indicators of diabetes care. Patients' blood sugar levels were monitored and generally appeared to be well-controlled.
- We reviewed a number of case notes and found that some patients with complex or multiple long-term conditions did not have an appropriately detailed care plan in their records. In these cases, the GP relied on their personal knowledge of their patients. While the GP demonstrated good familiarity with their patients' conditions, circumstances and treatment, this approach increased the risk that relevant information might be missed or not shared appropriately.
- The GP principal was meeting with community health professionals to discuss the care of relevant patients. They had met with the district nursing team on four occasions in the previous six months.
- The practice had systems in place to call patients with long-term conditions for regular review. We spoke with three patients with a long-term condition who confirmed they had a regular review with the GP and this included a review of their medicines.

Summary of findings

- Longer appointments and home visits were available for patients with more complex conditions when needed.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. However, the practice had not electronically 'flagged' the patient records of children known to be at risk.
- Immunisation rates were generally high for standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. We spoke with one parent who had recently registered with the practice. They were positive about the way they were listened to in this practice in comparison to their previous experience.
- Appointments were available after school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement 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. The practice had secured a female GP to provide two clinical sessions per week and routinely used chaperones.
- Practice uptake rates for cervical screening (83%) were in line with the national average (82%). The practice had been taking action to improve previously low uptake rates, for example following up non-attendance.
- The practice offered extended hours appointments on one day a week to try and ensure the service was accessible to patients with working or other daytime commitments.
- The practice offered an online repeat prescription service and online appointments. However, the practice did not have its own website.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. We were told that the practice invited patients on the learning disability register for a health check but few checks were recorded in the electronic patient records with no information about any resulting follow-up or changes to care.
- 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. However, the practice was not adding 'flags' to the electronic patient records when patients were known to be at risk of abuse or were otherwise in vulnerable circumstances. The electronic records system has the facility to automatically alert staff when a patient with a 'flag' in their record contacts or attends the practice.
- The practice monitored A&E attendance and non-attendance of booked appointments.
- The practice had arrangements to allow people with no fixed address to register or be seen at the practice.
- The practice actively engaged with local specialist drug and alcohol services to ensure that relevant patients received appropriate treatment and support, with a focus on recovery.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

- The practice was participating in a local scheme to provide patients with enduring mental health problems with greater monitoring and support in a primary care setting. The practice had few eligible patients but the GP reported positively on the benefits for these patients. This was because GP consultations could also cover physical health problems and more general health promotion and preventative advice in a local setting. The GP said they had also developed good working relationships with the local specialist mental health services.
- The practice scored highly for indicators of the quality of mental health care as measured by the Quality and Outcomes Framework (QOF) in 2014/15. For example, the percentage of patients with psychosis who had a care plan was 100% (compared to the national average of 88%). And 100% of practice patients diagnosed with dementia had received a face-to-face review in the preceding 12 months (compared to the national average of 84%).

Summary of findings

- However, when we reviewed the electronic records, we found that care plans and health checks were being poorly documented in the electronic patient records.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published on 2 July 2015. The results showed the practice was performing below average for some aspects of care and above average for others. Patient satisfaction with GP consultations in particular were low. Questionnaires were sent to 423 patients and 88 were returned.

- 79% of respondents found it easy to get through to this surgery by phone compared to the Ealing average of 69% and the national average of 73%.
- 79% found the receptionists at this surgery helpful (Ealing average 81%, national average 87%).
- 89% said the last appointment they got was convenient (Ealing average 87%, national average 92%).
- 37% usually waited less than 15 minutes after their appointment time to be seen (Ealing average 53%, national average 65%).
- 65% said the last GP they saw or spoke to was at giving them enough time (Ealing average 81%, national average 87%)
- 58% said the last GP they saw or spoke to was at involving them in decisions about their care (Ealing average 75%, national average 81%)
- 82% said the last nurse they saw or spoke to was at giving them enough time (Ealing average 85%, national average 92%)
- 76% said the last nurse they saw or spoke to was at involving them in decisions about their care (Ealing average 77%, national average 85%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards, all but one of which were wholly positive about the service. Positive feedback included comments about the speed of seeing the GP in an emergency and the GP's skills in listening and explaining test results and in providing successful treatment. The negative comment referred to an experience of a delayed appointment resulting in a long wait at the surgery.

We spoke with seven patients during the inspection. All seven patients said that they were happy with the care they received. Patients who had been attending the practice for a number of years told us they valued the continuity of care they received at the practice.

Dr Nader Lewis

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist advisor.

Background to Dr Nader Lewis

Dr Nader Lewis provides services to approximately 1700 patients in the surrounding areas of Ealing from a single surgery. The practice is also known as St Marks Medical Centre. The service is provided through a General Medical Services contract. The practice is accessible to people with disabilities.

The practice is owned and led by an individual GP principal (male). The practice currently employs a regular female GP for two sessions per week (both provided on one day). The practice also employs a practice manager and a small team of receptionists. At the time of the inspection, the practice was offering sessions with a contracted practice nurse but these were becoming irregular and it was unclear if the nurse was going to continue at the practice.

The practice is open Monday to Friday, 9.00am to 1.00pm and 3.00pm to 6.30pm, apart from Thursday when the practice closes from 1:30pm. The practice is also closed over the weekend. The practice provides GP surgery hours between 9.00am and 11.30am and between 3.00pm and 4.30pm on the afternoons when it is open. The practice also offers an extended hours surgery on Tuesday morning when appointments are available from 7.00am. The practice has introduced an electronic appointment booking system and an electronic prescription service.

Out of hours primary care is contracted to a local out of hours care provider. The practice provides patients with information in the practice leaflet, on an answerphone and on the practice door about how to access urgent care when the practice is closed. Patients are advised to ring "111" and are also provided with the telephone number to contact the local out-of-hours service directly.

The local practice population is similar to the English average in terms of levels of income deprivation and life expectancy. The practice has a high proportion of young adult patients aged between 20-44 years, with fewer than 100 patients (5%) aged over 75 years. In 2011/12, a third of the practice population had a health condition limiting daily life and 8% had a significant caring responsibility. These figures are lower than the English general practice average of 49% and 18% respectively. The local population is mobile, and culturally and ethnically diverse, with a large proportion of Polish patients.

The practice is registered to provide the following regulatory activities: family planning; maternity and midwifery services; diagnostic and screening procedures; and treatment of disease, disorder or injury. CQC previously inspected the practice in January 2014 with a follow-up visit in March 2014. The practice was compliant with all regulations inspected in March 2014.

Why we carried out this inspection

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

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. The 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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 August 2015 During our visit we:

- Spoke with the GP principal, the practice manager and the receptionists.
- Spoke with seven patients who used the service.
- Observed how people were greeted at reception
- Reviewed the personal care or treatment records of 20 patients.
- Reviewed 11 comment cards where patients and members of the public shared their views and experiences of the service.

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)

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. There was an effective system in place for reporting and recording significant events.

- Significant events were recorded in a separate book and the GP also kept a record of events relating to their own practice for discussion as part of their professional appraisal. The GP told us they were able to discuss significant events with GP colleagues in other practices in the area. Staff told us they would inform the practice manager of any incidents.
- The practice reviewed significant events to reduce the risk of reoccurrence and to identify improvements. We saw records relating to six recent events which had occurred over the last year. These included clinical and non-clinical events, all of which had been documented, discussed and actions noted.
- Safety alerts were received electronically by both the GP principal and the practice manager who discussed any that were relevant to the practice and implementation.

Overview of safety systems and processes

The practice had systems and processes in place to keep people safe and to safeguard them from abuse although these were not always comprehensive. For example:

- Arrangements were in place to safeguard children and vulnerable adultsfrom abuse. The practice had safeguarding and whistleblowing policies that were accessible to all staff and. were in line with relevant legislation and local requirements The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP principal was the practice lead for safeguarding. The GP 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. The GP was trained as required in safeguarding children to "level 3".
- However, we found that the practice was not updating the electronic patient records with known safeguarding risks. The electronic system includes the facility to add an alert (a 'flag') to the records of patients known to be at risk of abuse. Staff are then automatically alerted when the patient contacts or attends the practice to safeguarding concerns. Use of this facility ensures that new or temporary doctors and nurses are also made aware of known safeguarding concerns when seeing patients.
- A notice in the waiting room advised patients that the practice provided a chaperone service. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS check). (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). Staff we spoke with who acted as chaperones had a good understanding of the role and how to carry this out effectively and with the patient's consent. However, the practice was not recording in the patient notes when a chaperone had been used.
- We observed the premises to be generally clean and tidy although some areas needed greater attention, for example, the privacy curtains in the consulting rooms were made of fabric and had not been washed in the last two years. We found that the staff were aware of the importance of infection control and had received training. There were appropriate handwashing facilities, clear handwashing instructions displayed in treatment rooms and sufficient supplies of personal protective equipment. The practice did not use any clinical supplies that required sterilisation. However, the practice had not carried out an infection control audit in the last five years and could not assure us that it was monitoring infection control effectively. The practice manager was the infection control lead but said they were not fully confident of current guidelines in relation to infection control in primary care.
- The practice had appropriate arrangements for managing medicines and vaccinations. For example, the fridge had recently failed and had been replaced with a new model. The practice had responded sufficiently quickly to prevent deterioration of the vaccine stock. Prescription pads were securely stored and there were systems in place to monitor their use. The practice carried out reviews of prescribing, with the support of

the local Clinical Commissioning Group medicines management advisor. The GP principal was aware of how the practice was performing in relation to prescribing guidelines, for example they were aware that practice prescribing of quinolones (a class of broad spectrum antibiotics) was higher than average and this was an area for improvement. We were told that the practice carried out medication reviews with patients who were prescribed multiple medicines and several patients we spoke with said they had had a medication reviews. However medication reviews were not being recorded properly in the electronic patient records.

- We reviewed the recruitment records for four members of staff. The practice manager and staff members told us that appropriate recruitment checks had been undertaken prior to employment. However the practice did not keep comprehensive records of the evidence seen which made this difficult to verify. For example, the practice manager had not kept contemporaneous notes to show they had seen Disclosure and Barring Service (DBS) criminal records checks for all recently employed staff or locums.

Monitoring risks to patients

The practice assessed and managed risks to patients although some improvement was needed.

- The practice had various health and safety policies and carried out or arranged for health and safety checks to take place. These included inspections of fire safety equipment and emergency lighting. However, the practice could not show us any formal fire safety risk assessment; certificate of inspection of the electrical system or a legionella risk assessment and we could not be sure that these risks were being effectively managed. The practice had also not carried out any fire drills to test their fire safety procedures. Staff we spoke with were aware of how to exit the building and the gathering point.
- All electrical equipment and clinical equipment had been checked within the last year to ensure it was working safely and reliably. One set of scales had been found to be producing inaccurate readings when checked and was immediately replaced. The practice also had a variety of other policies and procedures to monitor safety of the premises such as control of substances hazardous to health, safe handling of 'sharps' and infection control.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The clinical skill-mix was one of the main challenges faced by the practice which had found it difficult to secure enough practice nurse input to meet patients' needs.
- At the time of the inspection, the practice employed a part-time female doctor and planned to gradually increase the number of sessions provided by a female GP. The practice had contracted with a practice nurse to provide two sessions per week.
- The practice had a buddy arrangement in place with neighbouring primary care practices to provide primary care services to practice patients when the GP principal was on planned leave.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. However, it did not have all the recommended emergency equipment and medicines available on the premises.

- The practice did not have emergency oxygen on site and had not carried out a risk assessment to show why this was unnecessary.
- 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. However, the practice did not stock the full range of recommended emergency medicines for primary care services, for example, there was no glucagon or antibiotics. There was no spillage kit.
- The practice had a defibrillator available on the premises with adult and children's masks. The staff had been trained on how to use the defibrillator and on basic life support. There was also a first aid kit and accident book.
- The practice kept a list of emergency contact numbers and had a buddy arrangement with a nearby practice which could be called on in the event of major incidents such as power failure or building damage.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care 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 keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. For example, the GP principal was able to show us how they accessed and implemented guidance on the management of hypertension and atrial fibrillation.
- The practice monitored that guidelines were followed through checks and reviews of patient records. However, the practice's ability to do this was limited. Clinicians were not sufficiently familiar with the electronic records system to record detailed patient notes, add relevant coding and carry out routine analyses and audit. Instead, the practice was relying on parallel paper record keeping, failsafe systems and audit.

Management, monitoring and improving outcomes for people

The practice did not make effective use of information to monitor outcomes for patients. For example the practice was achieving lower than average performance on the Quality and Outcomes Framework (QOF) and some of the enhanced services it was providing. (QOF is a system intended to improve the quality of general practice and reward good practice). In 2012/13 the practice achieved 89% of the total number of QOF points available, with 4.4% exception reporting. This performance was lower than the Ealing average (93%) and nationally (94%). The GP principal told us the practice was underachieving on QOF because they were unable to use the electronic patient record system (which had been installed the previous February). We observed the electronic records to be poorly coded and completed but could not verify whether actual practice performance was better than the recorded data suggested. Data from 2014/15 showed that:

- Performance for diabetes-related indicators was a little below the national average in relation to diabetic patients' last IFCC-HbA1c readings. Seventy percent of diabetic practice patients had a last recorded reading below 64mmol/mol compared to the national average of 78%. (This is an indicator of how well patients' blood sugar levels are being controlled). However, for other diabetes indicators the practice was achieving better than the national average. For example, 85% of diabetic patients' last blood pressure reading was in the normal range compared to 78% nationally. And, 99% of diabetic practice patients had been vaccinated against influenza in the previous 12 months compared to 94% nationally.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average (87% compared to 83% nationally).
- Performance for mental health related indicators was consistently better than the national average. For example 100% of practice patients with diagnosed psychoses had a documented care plan compared to 88% nationally. And 100% of practice patients with diagnosed psychoses had a record of their alcohol consumption in their notes compared to 90% nationally.

All practice patients diagnosed with dementia had received a face-to-face review of their care in the last 12 months compared to the national average of 84%.

We saw examples of clinical audits and reviews that the practice had carried out. For example the GP principal had reviewed practice prescribing rates for vitamin B12, benzodiazepines and thyroxine. The GP was able to describe actions taken in response to the findings. These were all single cycle audits and the practice had no plans to repeat them to check that good practice was being maintained. The practice was however in the process of completing one two-stage clinical audit reviewing the risk of osteoporosis in patients who were prescribed both protein pump inhibitors and particular types of painkillers. This audit was due to be repeated by October 2015. The ability of the practice to participate efficiently in local commissioner-led benchmarking, reporting and audit exercises was limited by the practice's difficulty in fully utilising their electronic patient record system.

Effective staffing

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

- The lead GP undertook continuous professional development to ensure they were up to date with

Requires improvement

Are services effective?

(for example, treatment is effective)

current guidance and kept a clear record of this activity as required. The GP was undergoing their five-yearly professional revalidation immediately after the inspection. The GP provided 80% of the clinical sessions at the practice and told us they had limited protected time for learning and development.

- The learning needs of non clinical staff were identified through appraisals, meetings and more informal discussions. Staff had access to appropriate training to cover the scope of their work. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support, chaperoning and information governance awareness. Staff had access to and made use of e-learning training modules, in-house training and the practice took advantage of external training opportunities for example, put on by the local clinical commissioning group.

Coordinating patient care and information sharing

Essential information needed to plan and deliver patient care and treatment was available to relevant staff through the practice's electronic patient record system and paper records.

- This information included medical records and investigation and test results. However, we found the practice was making very limited use of the electronic records system to document, integrate and coordinate information about patient care. For example, we found care planning templates were not being used by the GP and the practice was not using alternative methods of care planning. The GP demonstrated familiarity and knowledge of patients' particular cases but the lack of good recording increased the risk that relevant information might be missed or not shared in a timely way.
- Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services, for example when referring patients to other services. The GP followed-up referrals and reviewed all discharge letters although they did not have a structured system for updating care plans or routinely inviting patients for a follow-up consultation following discharge from hospital.
- The GP had put in place paper based "safety-netting"processes to ensure that patients who needed further investigation or treatment were not missed. The electronic systems for safety netting were not in use.

Staff worked with other health and social care services to understand and meet the range and complexity of people's needs. 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 meetings took place. For example the GP discussed complex cases every two months with the relevant consultants. The GP also attended a multi-disciplinary meeting to follow-up and prevent falls in older patients. The district nursing team kept a list of patients who needed extra support. The GP met the district nurses monthly and was sent the minutes of these meetings.

The GP also attended locality meetings with other local practices when possible. They said they had found these sessions which included discussion about local referral 'pathways' and updates useful but the meetings were not minuted for reference.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- The practice could not tell us of any patients who had made formal advanced decisions about their wishes and medical treatment. From the evidence of the records we reviewed, we were not assured that the practice currently had the capability to record any such decisions appropriately in the electronic patient record for future reference.

Health promotion and prevention

The practice identified patients likely to need extra support on a case by case basis, for example, older people with complex conditions or on the palliative care list. The

Requires improvement

Are services effective?

(for example, treatment is effective)

practice did not currently employ a health care assistant and the GP and practice nurse provided health promotion advice. One of the patients we spoke with said they had received good advice on managing their long-term conditions. The practice was able to give us examples of signposting patients to relevant agencies and support and had installed a television in the waiting room which provided health information and lifestyle advice.

- The practice's uptake for the cervical screening programme good with 83% of eligible women recorded as having had a smear in the previous five years compared to the national average of 82%. The practice was aware of this and told us they were improving uptake by actively following up non attendance.
- Childhood immunisation rates were generally in line with the Ealing average. For example in 2014/15, the practice had immunised 87% of babies in their first year with the 'five-in-one' vaccination compared to the Ealing average of 86%. Eighty-two percent of two year-old practice patients had received their first MMR compared to the Ealing rate of 83%.
- We were told that patients had access to health assessments and checks. New patients were required to complete a form covering medical history and a health screening questionnaire.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were welcoming and helpful to patients when they arrived at the practice.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity 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 said they could respond when patients' wanted to discuss sensitive issues or appeared distressed they could talk to them in a quieter area of the practice to discuss their needs.

All but one of the eleven patient CQC comment cards we received were positive about the service. Positive feedback included comments about the speed of seeing the GP in an emergency and the GP's skills in listening and explaining test results and in providing successful treatment. The negative comment referred to an experience of a delayed appointment resulting in a long wait at the surgery.

We also spoke with seven patients. They also told us they were pleased with the care provided by the practice. One patient commented that the practice was a "traditional" small GP practice and this suited them personally. Three patients had a long term condition and commented on receiving good continuity of care and regular reviews. Patients were confident that the GP knew and understood their medical history and health needs. Patients told us the practice was well organised, they had been referred promptly for tests and specialist treatment and the GP had followed-up their care after discharge. One patient with young children told us they had recently changed practices and were very pleased with this practice in comparison to their previous experience.

However, results from the national GP patient survey showed that the practice performed less well than other practices on questions asking about compassion, dignity and respect. The practice was performing below average for its satisfaction scores on consultations with doctors. For example:

- 63% said the GP was good at listening to them compared to the Ealing average of 84% and national average of 89%.
- 65% said the last GP they saw or spoke to was at giving them enough time (Ealing average 81%, national average 87%).
- 73% said they had confidence and trust in the last GP they saw (Ealing average 93%, national average 95%).
- 61% said the last GP they spoke to was good at treating them with care and concern (Ealing average 79%, national average 85%).
- 79% said they found the receptionists at the practice helpful (Ealing average 81%, national average 87%).

Care planning and involvement in decisions about care and treatment

Patients we spoke with said that 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 also reflected these views.

However, results from the national GP patient survey again showed that the practice was scoring consistently below average on these aspects of care and this is a concern. For example:

- 61% said the, the last GP they saw was good at explaining tests and treatments compared to the Ealing average of 81% and national average of 86%
- 58% said the last GP they saw was good at involving them in decisions about their care (Ealing average 75%, national average 81%).

The practice was unclear for the reasons for this and had not carried out further investigation, for example, with its patient participation group.

Staff told us that translation and interpreting services were available for patients who did not have English as a first language. We saw notices in the reception areas in a range of languages including Somali, Arabic, Albanian and Punjabi. The practice had recently employed a Polish

Requires improvement

Are services caring?

speaking receptionist as the practice had a large and growing proportion of Polish patients. The GP had also learnt a range of useful phrases in other languages to help communicate with patients with limited English.

Patient and 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, although we noted that some of the information for carers was out of date.

The practice's computer system had the facility to alert staff if a patient was also a carer. However, the practice was not consistently coding information about carers on this system and we found that the practice recorded little detail of carers' assessed needs. The practice was able to provide carers with written information about the various avenues of support available to them.

Staff told us that if patients were known to have suffered a bereavement, the practice contacted them and offered a consultation. The practice was aware of local specialist bereavement counselling services for adults and children.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed and was responsive to the particular needs of its population. The practice understood the socio-demographic and cultural profile of its population which had changed rapidly in the last five years. Around half of patients were Polish and a further 25% spoke Arabic. The practice had recruited a Polish-speaking receptionist who could also act as a chaperone.

- Most GP sessions were provided by the GP principal who was male. The practice was aware that female patients might prefer to see a female doctor and this was a potential barrier to access. In response, the practice had secured the services of a female GP one day a week, and routinely referred patients to a local clinic for procedures such as cervical smears. The GP used chaperones and also had an arrangement with a buddy practice if required.
- There were longer appointments available for people who might have greater difficulty communicating, for example patients with a learning disability or patients attending with an interpreter.
- Home visits were available for older patients and other patients who would benefit from these.
- Same day appointments were available for children and those with urgent medical conditions.
- The practice was generally accessible to people with disabilities although there was no hearing loop available.
- The practice had occasionally been approached by homeless patients and had registered and provide these patients with primary health care.
- The practice had a small number of patients with severe mental health problems or drug and alcohol problems and actively engaged with local specialist services to provide 'shared' care in line with current guidelines.

Access to the service

The practice was open Monday to Friday, 9.00am to 1.00pm and 3.00pm to 6.30pm, apart from Thursday when the practice closed from 1:30pm. The practice was also closed over the weekend. The practice provided GP surgery hours between 9.00am and 11.30am and between 3.00pm and 4.30pm on the afternoons when it was open. The practice also offered an extended hours surgery on Tuesday morning when appointments were available from 7.00am.

The practice held back a number of appointments each day to enable patients with urgent problems to be seen the same day. No pre-bookable appointments were available on Mondays so the practice could see patients on a priority and walk-in basis after the weekend.

The practice offered relatively restricted opening hours which it justified on the basis of having a small patient list size and staff team. Patients we spoke with said they were able to get appointments when they needed them. Results from the national GP patient survey confirmed that patients' satisfaction with access to care and treatment was generally comparable to or better than local and national averages, although a greater proportion of patients reported delays in the waiting room. For example:

- 68% were satisfied with the practice's opening hours compared to the Ealing average of 71% and national average of 75%
- 79% said they could get through easily to the surgery by phone (Ealing average 69%, national average 73%)
- 75% described their experience of making an appointment as good (Ealing average 66%, national average 73%
- 37% said they usually waited less than 15 minutes after their appointment time (Ealing average 53%, national average 65%).

Listening and learning from concerns and complaints

The practice had an effective 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.
- The practice manager was responsible for handling complaints.
- Information was available in the practice leaflet and displayed at reception to help patients understand the complaints system. These leaflets were not available in other languages commonly spoken by patients using the practice such as Polish however.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Three complaints had been received in the last 12 months. These had been managed in line with the practice policy. Clinical complaints were passed to the GP for investigation and a response. The practice wrote to complainants with the results and with information about how to take the complaint further if they were unhappy with the result. The practice included an apology and an explanation when a complaint was upheld.

Lessons were learnt from concerns and complaints, for example, relevant staff had discussed particular complaints and action was taken to as a result to improve the service and avoid any reoccurrence.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a written statement of purpose which set out its vision to deliver an accessible, high quality service ensuring good continuity of care for patients. The GP principal and practice manager had identified priorities for improvement, for example to secure sessions with a female GP. The practice had also started to consider longer term plans, for example, in relation to succession arrangements.

The practice was aware of demographic changes locally, the likely business implications of these and was keen that the service adapted to meet patients' changing needs. The practice did not have supporting written business plans identifying risks and opportunities.

Governance arrangements

The practice had governance arrangements in place which supported the delivery of the service. We found that:

- Staff were aware of their own roles and responsibilities and knew how to report any concerns.
- Practice policies were available to all staff although some policies, such as infection control, were not always specifically tailored to the practice.
- The GP principal and practice manager had a good understanding of the performance of the practice although this was not always carried through into formal reporting systems.
- The GP principal had recently undertaken clinical audit to monitor practice against established standards of good practice and to make improvements where necessary.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions although these were not always comprehensive or robust. For example, the practice could not show us a fire safety risk assessment or a formal business continuity plan. The practice was able to describe the actions it took when did have an understanding.
- However, practice documentation, for example on recruitment checks was not always complete. The practice was not always confident about current requirements and good practice for example, in infection control.
- We were told that the practice acted on NHS and other formal safety alerts relevant to general practice. The practice manager discussed relevant alerts with the GP principal as a check they had been actioned.
- The practice had clinical 'failsafe' systems in place to ensure for example, that patient test results and referrals were followed-up appropriately. These systems tended to be paper based and run in parallel to the electronic patient records system which already included this sort of functionality.
- The practice did not have a structured induction programme for new or temporary staff. We spoke with one member of staff who had recently joined the practice who said they had been shown practice procedures and policies and had time with the practice manager to learn about their role. The lack of a structured programme however increases the risk that certain procedures may be missed or poor performance not picked up at an early stage.

Leadership, openness and transparency

The GP principal and practice manager had the experience, capacity and capability to run the practice. The GP principal and practice manager were visible in the practice and staff told us that they were approachable and listened to staff concerns.

- The practice held team meetings every two months or so and kept a record of the agenda and minutes. These meetings were used as a learning opportunity with reviews of practice policies and processes.
- Administrative staff received an annual appraisal to review performance and identify opportunities for further development and training. One of the staff gave us an example of additional training they had undertaken following a discussion at their appraisal.
- Staff told us that there was an open culture within the practice and it was a friendly and supportive place to work.

Are services well-led?

Requires improvement

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

- Staff had confidence in the GP principal and practice manager to act on concerns. One staff member gave us an example of raising a potential safeguarding concern with the GP principal who acted promptly and sensitively to follow this up.
- However, the GP principal was making limited use of the patient electronic record system and this impacted on the practice team as a whole.

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

The practice encouraged patients to feedback through the national Family and Friends test and also provided patients with information about how to make a complaint.

- The practice had started to set up a patient participation group (PPG) and had identified 13 potential members including carers. However it had proved difficult to find a date that PPG members were willing to attend. At the time of the inspection, the practice was not actively engaging with this group.
- The practice was aware that it was under-performing in the national GP patient survey but was unclear why this was the case. The practice had not carried out any investigation into patient experience in more detail and whether and how this might be improved.
- The practice pointed to the increased popularity of the practice with Polish patients as evidence of positive feedback through word of mouth recommendation. The practice had not actively sought to engage with this group of patients however, for example with feedback forms translated into Polish.
- The practice had a small staff team and obtained feedback from staff members informally or through staff meetings. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with management.

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not fully assessed the risks to the health and safety of patients and done all that is reasonably practical to mitigate such risks.** **In particular we found the practice was not prepared for dealing with medical emergencies. Staff did not have access to emergency oxygen and no risk assessment had been undertaken to show why this was not require** **Regulation 12 (1)(2)(a)(b)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not maintaining an accurate, complete and contemporaneous record in respect of each patient. For example, patient records were sometimes missing relevant information on medication reviews, use of chaperones, the outcome of health checks, or other information required for effective care planning. The practice was not adding codes or 'flags' to the records of patients known to be at risk or vulnerable. This impacted on the practice's ability to effectively assess and monitor the quality and safety of services. The provider could not assure us that all environmental risks were appropriately assessed, monitored and managed. For example, the practice could not show us a fire safety risk assessment or a legionella risk assessment. The practice did not routinely audit its infection control and was not confident it was fully up-to-date with current infection control guidance for primary care settings.

This section is primarily information for the provider

Requirement notices

The practice was not maintaining necessary records of recruitment, such as proof of identity, to show that all new staff were suitable to work in a health care setting.

The practice consistently scored below average on the national GP patient survey. The practice had done little to actively engage with patients to investigate whether these results reflected patient experience in the practice and if so, how it might be improved.

Regulation 17 (1)(2)(a)(b)(c)(d)(i)(e)(f)