102 The Avenue Surgery

Quality Report

102 The Avenue
West Ealing
London
W13 8LA
Tel: 020 8997 2525
www.102theavenue.co.uk

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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?	Outstanding
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 102 The Avenue Surgery on 20 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be requiring improvement for providing safe services, good for providing effective, caring, and well-led services and outstanding for providing responsive services. It was outstanding for providing services for people whose circumstances make them vulnerable and people experiencing poor mental health. It was good for providing services for older people; people with long term conditions; families, children and young people; working age people (including those recently retired and students) and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed in a timely manner.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

We saw two areas of outstanding practice:

- The practice provided a specialised service for homeless people at a local hostel which included a drop-in clinic once a month at the hostel. This catered for residents registered with the practice who declined attendance at the practice or the local hospital. Service provision included treating severely mentally ill patients with complex mental, social and physical problems. The practice also operated an open surgery at the practice each morning between 10am-11am which particularly catered for homeless patients who did not have the resources to telephone the practice for an appointment.
- The practice had an in-house counselling service where patients could access weekly counselling sessions to treat bereavement, depression, anxiety, relationship issues, sexuality orientation and managing long term conditions such as Parkinson's disease. The GPs worked closely with community psychiatrists to review mental health patients to facilitate better communication regarding patients overall care.

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

Importantly the provider must:

- Ensure Disclosure and Barring service (DBS) checks are undertaken for all staff who undertake chaperone duties at the practice or undertake a risk assessment if the decision is made not to perform DBS checks.

The provider should:

- Ensure all staff who undertook chaperone activities were suitably trained.
- Ensure availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site.

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 and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated with staff to support improvement. Staff had received training in safeguarding and they were aware of the steps to take if they had any concerns. Systems were in place to ensure medicines were managed safely and equipment was properly maintained. We were told there were sufficient staff members to keep people safe. However, administrative staff had not received any formal training in chaperoning, Disclosure and Barring Service (DBS) checks had not been undertaken for all administrative staff who provided chaperone duties at the practice and this had not been risk assessed. Staff had been trained to respond to medical emergencies and plans were in place to deliver continuity of care during potential disruptions to services. Health and safety was monitored and where risks were identified, control measures were in place to minimise them. However a risk assessment had not be completed following the decision to not have an automated external defibrillator (AED) on site.

Are services effective?

Good

The practice is rated as good for providing effective services.

GPs carried out thorough assessments of patients' needs and these were reviewed when appropriate in line with professional guidelines. The practice had a system in place for completing clinical audit cycles and we saw evidence of improved outcomes for patients as a result. Staff were suitably qualified to deliver effective care and treatment and the practice worked with other health care professionals to deliver effective care to those patients with more complex needs. Consent was sought from patients when appropriate and staff had a working knowledge of key legislation such as the Mental Capacity Act 2005. The practice provided a range of health promotion services and had performed well in areas such as childhood immunisations and cervical screening.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

Summary of findings

about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice had an in-house counselling service where patients could access weekly counselling sessions.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

The practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address these identified needs. The practice had recognised the needs of different groups in the planning of its services including those whose circumstances make them vulnerable, patients with learning disabilities, long-term conditions, poor mental health, older patients and children.

The practice provided a specialised service for homeless people at a local hostel which included a drop-in clinic once a month at the hostel. Service provision included treating severely mentally ill patients with complex mental, social and physical problems.

The practice had an in-house counselling service where patients could access weekly counselling sessions to treat bereavement, depression, anxiety, relationship issues, sexuality orientation and managing long term conditions such as Parkinson's disease. The GPs also worked closely with community psychiatrists to review mental health patients to facilitate better communication regarding patients overall care.

The practice had a Patient Participation Group (PPG) and had made changes to the way it delivered services as a consequence of feedback from patients. The practice had a system in place for handling complaints and concerns and the system was working efficiently.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision, and governance arrangements in place. There was clear leadership and staff were aware of who they were accountable to and their level of responsibility. Regular meetings were held, staff were supported with training and their

Summary of findings

performance was monitored through annual appraisals. The practice gained feedback from staff and patients and acted on it to improve services. The patient participation group (PPG) was active. The practice used clinical audit to improve outcomes for patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

We found older patients were treated with dignity and respect. The practice offered proactive, personalised care to meet the needs of the older people in its population. Patients over the age of 75 years had a named GP. The practice offered a home visit service for those patients who were housebound. The practice had undertaken care planning for older patients and their care reviewed appropriately. Care plans for those with complex needs were reviewed monthly and where appropriate, discussed at multi-disciplinary meetings to ensure multi-disciplinary input. Staff were able to recognise the signs of abuse in older patients and they were aware of the procedures to report any concerns. The practice worked with other specialists to provide effective care for older patients including end of life care.

People with long term conditions

Good

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

The practice kept a register to monitor the health of patients with known long-term health conditions, such as chronic obstructive pulmonary disease, diabetes, asthma, heart disease and hypertension. Longer appointments and home visits were available as required. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. There was a recall system in place with monthly audits to identify patients to attend health check appointments.

For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people

The practice allocated five appointments each morning at 10am for mothers with small children. The practice provides both antenatal and postnatal care, a baby clinic for new mothers and childhood immunisations. Audits were carried out to regularly check for

Summary of findings

compliance with the childhood immunisation programme. All staff were trained in safeguarding children and were aware of the procedures to follow if they were concerned about a child's wellbeing and welfare.

Cervical smear tests were provided for women between the ages of 24-65 and there was a recall system in place. Educational material was available for patients regarding sexual health clinics and contraception. All young patients who registered with the practice are advised about genital examinations and the use of alcohol, drugs and smoking.

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. For example, telephone consultations were available and extended hours offered a wider choice of appointment times.

The practice participated in a catch up programme for students aged 17 and above for the measles, mumps and rubella (MMR) and meningitis C (MEN C) vaccinations.

Repeat dispensing was provided for patients with controlled medical conditions such as hypertension and hypothyroidism in which a six month supply of prescriptions are sent to a chosen pharmacist. The practice also communicated blood pressure readings via email or post where appropriate.

The practice was proactive in offering online information for patients through the use of the practice website, Facebook page and blog however there was no online provision for booking appointments and ordering repeat prescriptions.

People whose circumstances may make them vulnerable

Outstanding

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

The practice held a register of patients living in vulnerable circumstances including those with a learning disability and homeless people. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. GPs used Makaton resources to aid communication with

patients with learning disabilities and where appropriate, patients were given a report with pictorial diagrams to take home following their annual review. Longer appointments were offered for people with a learning disability.

The practice provided a specialised service for homeless people at a local hostel. The practice worked closely with community psychiatrists and the hostel warden and to manage residents with complex mental, social and physical problems. Where appropriate, care plans were developed for residents and their treatment discussed at multi-disciplinary group meetings. The GPs provided a drop-in clinic once a month at the hostel which catered for residents who declined attendance at the practice or the local hospital. The practice operated an open surgery between 10am - 11am in which patients were offered appointments on a first come first served basis which catered for vulnerable patients such as homeless persons registered with the practice who were not able to telephone the practice for an appointment.

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

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

Patients with mental health conditions were provided with a full health check upon registration with the practice. The practice had a dementia register and patients on the register had received annual dementia reviews and medication reviews. Staff had received training in dementia to improve the awareness of the needs of patients with dementia. Dementia screening was carried out during the development of care plans or if staff members alerted GPs to any issues which might indicate the early onset of dementia.

All mental health patients had a three to six month review as appropriate. Care plans were in place for patients with poor mental health and these were reviewed annually. Longer appointments were available for those patients with poor mental health and the practice accommodated patients with acute mental health problems with appointments around midday for longer consultations in a less hectic atmosphere.

Summary of findings

The practice used the IAPT (improving access to psychological therapies) service and an IAPT counsellor used one of the practice's consultation rooms on a weekly basis to provide this service for both patients registered with the practice and other patients registered at GP practices within the GP network.

The practice also had an in-house counsellor who provided weekly counselling sessions for the practice's patients on Wednesday afternoons and early evening. The counsellor treated patients for bereavement, depression, anxiety, relationship and sexuality issues and some patients with long term conditions such as Parkinson's disease.

The GPs worked closely with community psychiatrists to review patients to facilitate better communication regarding patients overall care. The practice provided a specialised service for homeless people at a local hostel which included treating severely mentally ill patients with complicated mental, social and physical problems. These patients were closely monitored and where appropriate care plans were developed for them and their care discussed at multi-disciplinary meetings.

Summary of findings

What people who use the service say

We spoke with six patients during the course of our inspection including three representatives of the Patient Participation Group (PPG). We reviewed 40 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service; the results of the practice's most recent patient experience survey and the national patient survey 2014.

All the patients we spoke with were positive about the practice and the vast majority of the CQC comment cards stated that the service was 'good', 'very good' or 'excellent.' Patients said all the staff were friendly and treated them in a respectful manner. Patients were satisfied with the practice's opening hours and the standard of care they received.

Areas for improvement

Action the service MUST take to improve

- Ensure Disclosure and Barring service (DBS) checks are undertaken for all staff who undertake chaperone duties at the practice or undertake a risk assessment if the decision is made not to perform DBS checks.

Action the service SHOULD take to improve

- Ensure all staff who undertook chaperone activities were suitably trained.
- Ensure availability of an automated external defibrillator (AED) or undertake a risk assessment if a decision is made to not have an AED on-site.

Outstanding practice

- The practice provided a specialised service for homeless people at a local hostel which included a drop-in clinic once a month at the hostel. This catered for residents registered with the practice who declined attendance at the practice or the local hospital. Service provision included treating severely mentally ill patients with complex mental, social and physical problems. The practice also operated an open surgery at the practice each morning between 10am-11am which particularly catered for homeless patients who did not have the resources to telephone the practice for an appointment.
- The practice had an in-house counselling service where patients could access weekly counselling sessions to treat bereavement, depression, anxiety, relationship issues, sexuality orientation and managing long term conditions such as Parkinson's disease. The GPs also worked closely with community psychiatrists to review mental health patients to facilitate better communication regarding patients overall care.

102 The Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a GP and Practice Nurse Specialist Advisors. The Specialist Advisors were granted the same authority to enter 102 The Avenue Surgery as the CQC inspector.

Background to 102 The Avenue Surgery

102 The Avenue Surgery provides GP primary medical services to approximately 3,000 patients living in the London Borough of Ealing.

Ealing has significant income related inequalities with a high proportion of unemployment and 19.2% of children living in poverty. The practice serves a population of mixed ethnicities and a cross-section of ages.

The practice team is made up of two female GPs, a practice nurse, practice manager, three receptionists, a secretary and an administrator.

Opening hours are between 8.00am - 6:15pm on Mondays, 8:30am - 6:00pm on Tuesdays, 8:30am -8:00pm on Wednesdays, 8:30am - 1:00pm on Thursdays and 8:30am - 5:00pm on Fridays. GP appointments are available between 9:00am - 6:00pm on Mondays, 9:00am - 4:00pm on Tuesdays, 9:00am - 8:00pm on Wednesdays, 9:00am - 11:00am on Thursdays and 9:00am - 4:00pm on Fridays. Telephone access is available during core hours and home visits are provided for patients who are housebound or are too ill to visit the practice. There are telephone consultations available daily. During out of hours care is provided through an out of hours provider and patients are also referred to the '111' service.

The practice has a General Medical Services (GMS) contract (GMS is one of the three contracting routes that have been available to enable the commissioning of primary medical services).

The practice is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder and injury.

The practice provides a range of services including maternity care, family planning, sexual health, chronic disease management, counselling, childhood immunisations and smoking cessation.

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. 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.

Detailed findings

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. These 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 including information published on the NHS choices website and the national patient survey 2014. We asked other organisations such as NHS England and Ealing Clinical Commissioning Group (CCG) to share what they knew about the service.

We carried out an announced visit on 20 January 2015. During our visit we spoke with a range of staff including GPs, the practice nurse, practice manager and reception staff. We spoke with six patients who used the service and three members of the practice's Patient Participation Group. We reviewed comment cards completed by 40 patients sharing their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety, for example incident reports, complaints, safeguarding concerns and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns and how to report incidents and near misses. For example, as a result of an incident relating to a patient faint during a blood test procedure, the practice had undertaken a review of the layout and the access to the clinical room. Patients we spoke with during the inspection told us they felt their care and treatment at the practice was safe.

We reviewed minutes of practice meetings where incidents and complaints were discussed during the last 12 months and reviewed incident reports which had been collated for the last eight years. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events and incidents were reported on a standardised form which included details of the event and specific action required to prevent a reoccurrence. The practice had a significant event policy which included a process for communicating the outcome and learning to relevant staff. Staff including receptionists were aware of the process to follow and reported incidents to the practice manager. Staff we spoke to were able to provide examples of recent incidents reported and told us that incidents were discussed at practice meetings to ensure all staff were kept informed. We saw evidence of significant events being discussed as part of the clinical meetings and an 'Incident Reporting Log' spreadsheet which was stored on the shared drive for staff to access.

There were records of significant events that had occurred during the last eight years and we were able to review these. An example of a significant event related to an unwell baby who was not prioritised for an appointment following attendance at the practice. As a result of learning from this incident, the practice introduced the use of thermometers at reception to monitor temperature and allocated five urgent appointment slots within the appointment system specifically for children.

National patient safety alerts were disseminated by the Practice Manager via email to practice staff. We saw evidence of a safety alert relating to Ebola which had been disseminated to practice staff. Staff we spoke with were able to give an example of a drug safety alert that the practice actioned. The drug safety alert instructed that there was an increased risk of myopathy (muscular disease) as a result of the interaction of high-dose simvastatin and amlodipine medications used to treat cholesterol and high blood pressure respectively . The practice actioned this safety alert by providing alternative medication and halving the dose of amlodipine medication for patients who were also prescribed simvastatin.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a safeguarding policy in place for children which included contact details for local child protection teams. Flowcharts detailing the process for escalating safeguarding concerns were posted in consultation rooms and in reception for quick reference, to ensure staff reported any concerns promptly.

We examined training records during the inspection which included certificates of training completed. Training certificates showed that all staff had received relevant role specific training in child protection. All administrative staff were trained at Level 1 and all clinical staff were trained at Level 3 in accordance with national guidance. The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

We asked reception staff about their most recent training. Staff we spoke to were able to describe signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Safeguarding contact details including social services and

designated child protection doctors were easily accessible and were available in a folder kept in reception. The practice maintained a register of children who were vulnerable and at risk. One of the GPs and the practice manager had also received training in Female Genital Mutation (FGM) in addition to their safeguarding children training. Within the population of the borough of Ealing a number of residents have an ethnic background of which FGM is a cultural practice. There was an alert message system to highlight vulnerable patients on the practice's electronic records.

The practice had a chaperone policy and signs were visible in the waiting area and in the consultation rooms offering the chaperone service. The chaperone policy contained guidelines on who could act as a chaperone, the role of the chaperone and confidentiality requirements. The policy strongly recommended that chaperoning should be provided by clinical staff familiar with procedural aspects of personal examination. However, if clinical staff were not available to act as chaperones, administrative staff were required to provide this service. Administrative staff had not been provided with any formal chaperone training and some of the staff we spoke with were unclear about their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Disclosure and Barring Service checks had been performed for clinicians but not all administrative staff providing chaperone duties had undergone a criminal records check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a cold chain procedure for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a breach of these temperatures. The fridge temperature was checked and documented twice a day and we saw records of these checks being undertaken for the last six years and the appropriate temperature range had been maintained.

The practice nurse and the practice manager were responsible for ensuring medicines were in stock and within their expiry dates. We saw evidence of a spreadsheet which detailed all of the medications and perishable equipment in the practice so that stock could be checked for quantity and expiry dates. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Vaccines were administered by the practice nurse using directions that had been produced in line with legal requirements and national guidance.

There was a policy for repeat prescribing which was in line with national guidance and was followed in practice. The policy complied with the legal framework and covered all required areas. For example, how changes to patients' repeat medicines were managed. We saw evidence of prescription training was part of the administration staff induction programme. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice has a cleaning contract with an external agency and we saw evidence of cleaning task sheets and schedules. Patients we spoke with raised no concerns about the cleanliness of the practice and the comment cards we received also reflected this.

The practice nurse was the lead for infection control for the practice who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received induction training about infection control specific to their role. We saw evidence of annual infection control audits and improvements identified for action were completed on time.

An infection control protocol and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the practice had a clinical waste management protocol in place and waste was segregated, stored safely and disposed of by a professional waste company. Personal protective equipment (PPE) including disposable gloves and aprons were available for staff to use to minimise cross-infection risks. We saw evidence of a process for the management of bodily fluid spillages and separate spillage kits were kept in the reception and treatment rooms for spillages of vomit, urine and blood.

Requires improvement

Are services safe?

There was also a protocol for needle stick injuries which included immediate actions following an injury and contact details for needle stick injury advice from local hospitals and the occupational health department. The practice had a contract with an external agency for the safe removal and disposal of sharps waste. We noted that the sharp bins in the treatment rooms were out of reach of children but at a height which allowed safe disposal.

Clinical specimens were collected from the practice by an external agency. We saw evidence of the Hepatitis B status of clinical staff had been checked and non-clinical staff we spoke with confirmed that they did not come into contact with blood samples and did not handle these directly.

Hand washing facilities were available throughout the practice and posters were displayed above sinks with correct hand washing techniques. Alcohol gel and hand washing sinks with hand soap and paper towels were available in the treatment rooms.

An external agency had carried out a legionella (a germ found in the environment which can contaminate water systems in buildings) risk assessment for the practice.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

The practice had a contract with an external agency to provide portable appliance testing (PAT) and calibration of equipment on a routine annual basis. Examples of equipment calibrated included blood pressure monitors, Doppler ultrasound equipment and spirometers. All portable electrical equipment displayed stickers indicating the next testing date which was due in February 2015.

Staffing and recruitment

During our inspection we reviewed all of the staff files. The practice had a recruitment checklist procedure and the staff files we looked at contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body, employment history and references. However, we noted that criminal records checks through the Disclosure and Barring Service (DBS) had not been undertaken for some of the administrative staff who provided chaperoning duties and this had not been risk assessed.

The practice provided a comprehensive induction for staff as part of part of the recruitment process. We saw an example of an induction programme for administrative staff which included administration duties, significant event processes and emergency procedures.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and there was an appropriate skill mix to facilitate the clinics being provided. Administrative staff annual leave was organised by the practice manager and locum GP's were rarely booked for clinical sessions as the practice would try to cover staff annual leave and sickness internally.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and we saw evidence of an employee handbook containing health and safety information which was provided for staff as part of induction. The practice manager was the nominated health and safety representative.

The practice accessed an external agency to provide health and safety risk assessments. We saw evidence of these health and safety risk assessments where identified risks were logged in a risk assessment table. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Clinical staff had undertaken

Requires improvement

Are services safe?

annual basic life support training and administrative staff received training every three years in line with national guidance. We also saw posters for adult and child basic life support procedures displayed on treatment room doors.

Emergency equipment was available including access to oxygen and a pulse oximeter (used to check the level of oxygen in a patient's bloodstream). All of the staff we spoke with knew the location of this equipment within the practice. The practice did not have a defibrillator (used to attempt to restart a person's heart in an emergency) and had not risk assessed the decision to not have a defibrillator on-site.

Emergency medicines were available within one of the consulting rooms and the practice nurses' room of the practice and all staff knew of their location. We saw evidence that the emergency equipment and medication was checked regularly to ensure the stock was maintained and suitable for use. The emergency medication included those for the treatment of cardiac arrest, asthma attacks and anaphylaxis. Anaphylactic kits containing adrenalin was available in one of the consulting rooms and flowchart posters were displayed with the procedure to follow in the event of a patient experiencing anaphylactic shock within all the clinical rooms. All of the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Emergencies identified within the plan included loss of computer systems, medical records, telephone systems, electricity and water supplies and staffing issues. The business continuity plan contained a comprehensive list of contact details for staff to refer to for example electricity and gas suppliers.

The practice had a fire safety policy, staff had received fire training and we saw evidence of fire procedure notices displayed throughout the practice. Fire alarm checks were undertaken and fire drills had been practiced to ensure patients and staff could be evacuated in the event of a fire. An external agency provided fire protection equipment servicing and a fire risk assessment for the practice had been carried out to identify actions required to maintain fire safety.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs met weekly to discuss guidelines however this was an informal meeting and was not recorded or minuted. Staff we spoke with provided evidence of an example of a NICE guideline relating to the prescribing of statins (statins are a group of medicines that can help lower the level of low-density lipoprotein (LDL) cholesterol in the blood) that had been implemented in which the threshold for prescribing was changed to improve treatment for patients with atrial fibrillation and we saw evidence of this practice being changed. We found from our discussions with the GPs and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

We found that the practice followed prescribing guidance from the Clinical Commissioning Group (CCG) medicines management team. We saw evidence that the practice was within the prescribing budget and had worked with the prescribing advisor for the local CCG to find alternative medications within the prescribing budget.

The GP partners led in specific disease areas including diabetes, hypertension, chronic obstructive pulmonary disorder (COPD) and asthma. The practice nurse supported this work which allowed the practice to focus on patients with these conditions. Annual reviews were carried out on patients with long-term conditions in accordance with NICE guidelines.

The practice used a risk profiling software which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. Patients with risk factors such as chronic obstructive pulmonary disorder (COPD), diabetes, and patients with poor mobility who were living alone, were provided with care plans developed by the GPs. These care plans informed patient what to do when they felt unwell to prevent unnecessary attendances to A&E and hospital. The GPs met once a month to discuss the care plans of vulnerable patients and we saw evidence of a spreadsheet which identified these patients and provided a record of these meetings.

The practice used a referral management service to organise patient referrals and the local CCG produced the referral pathways. The GPs we spoke with informed us that in the previous year they had identified that they had been over-referring patients to secondary care for cardiology, gynaecology and musculoskeletal conditions. To address this issue, staff education had been increased and GPs had documented how they had appropriately avoided referrals. The practice had also endeavoured to increase patient education regarding their conditions for example through the use of YouTube videos which were posted on the practice website.

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

Management, monitoring and improving outcomes for people

The practice had achieved 6.1% above the local CCG average and 6 .2 % above the England average for the overall Outcomes Framework (QOF) targets in the year ending April 2014. QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services.

The practice showed us examples of clinical audits that had been undertaken over the last year. These included prescribing, immunisations, asthma, referrals to secondary care and cancer care. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, in response to new guidelines, the practice undertook an audit of patients with atrial fibrillation and applied the new risk calculator which resulted in the identification of patients who required new anticoagulation medication to reduce their risk of stroke. Following the audit, the GPs carried out medication reviews for patients identified and their medication was altered in line with the guidelines. This audit was repeated and the audit cycle was completed. The

Are services effective?

(for example, treatment is effective)

re-audit identified that the practice had managed to continue following the guidelines and there was an improvement from 83% to 100% of patients with atrial fibrillation receiving the correct treatment.

The practice had a palliative care register and palliative care patients had a named GP. The practice had regular internal as well as multidisciplinary meetings to discuss End of Life Care and the support needs of patients and their families. The practice liaised with palliative care teams for End of Life Care planning which included the patient's wishes for preferred place of death and Do Not Attempt Resuscitation (DNAR) orders. As a result, the practice had noted that there was an increase in more patient deaths occurring in their preferred place of death, including at home. We also saw evidence of cultural needs being taken into account into the care plans of patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with one of the GP partners being qualified as a pharmacist and having a special interest in International Normalised Ratio (INR) monitoring and warfarin initiation. Both doctors also having a special interest in obstetrics. All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example some administrative staff were being supported to undertake a National Vocational Qualification (NVQ) in information technology and one administrative staff member told us that she was also being supported to undertake an English and Mathematics training course.

The practice nurse was expected to perform defined duties and was able to demonstrate that they were training to fulfil these duties. For example, the practice nurse had a certificate in diabetes care and supported the GPs to manage patients with diabetes.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. All staff we spoke with understood their roles in working with other services and felt that the system in place in the practice worked well. Staff told us that there were no instances within the last year of any results or discharge summaries which were not followed up appropriately. Hospital discharge letters were actioned daily and we saw evidence on the electronic system that all discharge letters to be actioned had been received within the last 24 hours.

The practice was participating in an Enhanced Service for unplanned admissions to reduce unnecessary emergency patient admissions to secondary care by using a risk stratification tool to identify patients at risk of unplanned admission to hospital and manage their care proactively. In addition to participating in this Enhanced Service, the practice liaised with the local intermediate care response team who provide rapid assessment for patients in their home following a referral and develop a multi-disciplinary plan of care for the next three to seven days, supporting the patient at home to avoid admission to hospital or A&E.

Multidisciplinary group meetings were attended by clinical staff every two months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by consultants for the care of the elderly, diabetic consultants, mental health workers, community matrons, social worker, community psychiatric nurse, diabetic nurses and community pharmacists. Staff felt these meetings worked well and were a useful forum for sharing important information.

The practice worked with local psychiatrists to care for severely mentally ill patients registered with the practice. The GPs met with psychiatrists and patients at their consulting rooms or requested that psychiatrists attended the practice in cases where patients had experienced

Are services effective?

(for example, treatment is effective)

difficulties in engaging with various services and were at risk of relapse. The GPs told us working with the psychiatrists facilitated the exchange of useful information and both parties were able to be alerted to complications for patients such as drug interactions in comorbidities such as diabetes, COPD, asthma, and cardiovascular disease and any social issues in a timely way.

The practice worked with local hostel staff to improve the care of residents with diabetes for example through glucose testing and awareness of diabetes control.

The practice worked with a local CCG pharmacist to manage patient medication prescribing. The pharmacist visited the practice twice per week and as an independent prescriber, was involved in reviewing patient repeat prescriptions, recalling patients who require blood tests such as those on methotrexate medication and identifying any potential medication side effects by reviewing patient notes of their last consultation.

The practice was approved as a training practice for foundation year two (F2) doctors. Doctors are known as foundation doctors while on the training programme. Depending on the year of the programme they are on, they are known as foundation year 1 doctors (F1) and foundation year 2 doctors (F2). The practice worked with a local training hospital to support medical students in completing their foundation training. As part of their training the practice arranged for the students to visit the hostel to improve their awareness of mental health problems with comorbidities and social problems

Information sharing

The practice used electronic systems to communicate both between colleagues and with other providers. The GPs used an electronic Out of Hours Alert Form to inform the Out of Hours Service of patients with complex issues who were at risk such as palliative care and mental health patients. The practice also used an electronic system to inform patients via mobile phone text message of the '111' service in order to avoid unnecessary hospital A&E attendance.

The practice had systems to provide staff with the information they needed to fulfil their role. An electronic patient record was used by staff to coordinate, document and manage patients' care and staff had been trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. Formal training in the Mental Capacity Act 2005 had been undertaken by GPs. All of the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, GPs provided examples of applying the Deprivation of Liberty standards for some patients on a few occasions which involved working with Independent Patient Advocates and these cases were discussed and minuted at the multi-disciplinary group meetings. One of the GP partners had also undertaken 'Do Not Attempt Resuscitation' (DNAR) training and all appropriate patients were given a copy of their DNAR form to keep within their home.

GPs demonstrated an understanding of both Gillick and Fraser guidelines (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). Staff we spoke with were able to provide an example of applying this guideline in relation to a 15 year old patient at risk of pregnancy who was competent to make decisions about her care and was prescribed contraception. The practice had a consent protocol which detailed the Gillick competency assessments.

Patients with a learning disability and those with dementia were supported to make treatment decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed every two to three months (or more frequently if changes in clinical circumstances dictated it). Patients with learning disabilities also had an annual full medical check and where appropriate, patients were given a report with pictorial diagrams developed as part of the "Treat me Right!" initiative by Mencap, the leading UK charity for people with learning disabilities. The GPs also used Makaton resources to aid communication with patients with learning disabilities. Makaton is a

Are services effective?

(for example, treatment is effective)

language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, all young patients upon registration with the practice are advised about genital examinations, smears and the use of alcohol, smoking and drugs. The GPs carried out dementia screening where appropriate during the development of care plans or if staff members had alerted them to any patient issues which might indicate the early onset of dementia. Practice staff had undertaken dementia training to improve their awareness of the needs of patients with dementia through the use of the 'Barbara's story,' a dementia training film developed by nurses at one of the London hospitals.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and diabetic and these groups were offered further support in line with their needs. The practice referred patients to a local obesity clinic, gym facilities which offered referred patients reduced membership fees and 'Right Start,' a locally-developed structured education programme for patients with type 2 diabetes.

One of the GP partners had developed an internet practice blog to communicate information with patients online. We saw evidence of health promotion information being posted through this facility such as information on Ebola, risk factors for the development of various types of cancer and understanding mental health.

The practice's performance for cervical smear uptake was 71.3% which was above the local CCG target of 69.6%.There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national mammography and bowel cancer screening were above average for the local CCG. Breast screening uptake was 64.6% and bowel screening was 57% which was above the local CCG averages of 63.3% and 46.1% respectively.

The practice offered a range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice uptake of immunisations for two and five year old children was 90%. The practice performance for the uptake of flu immunisations for patients over 65 years of age was 73.7% which was above the local CCG target of 67.6%.

At the time of our inspection the practice were trying to recruit a new Health Care Assistant to be able to provide a smoking cessation service for patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014. We spoke with six patients during our inspection and we received 40 Care Quality Commission (CQC) comment cards completed by patients to provide us with feedback on the practice.

The evidence from all these sources showed that the majority of patients were satisfied with their GP practice. We received 40 comment cards and the vast majority of these stated that the service was 'good', 'very good' or 'excellent.' Results of the national patient survey showed that 85% of patients would recommend this surgery to someone new in the area which was above the local CCG average of 70%. 91% of patients stated that the last GP they saw or spoke to was good at treating them with care and concern.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice reception was open plan in design but the waiting area was located away from the reception desk and we saw poster notices requesting that patients approached the reception desk one at a time which helped keep patient information private. During our inspection we observed patients adhering to this notice. Staff gave us examples of how they ensure patient privacy was maintained which included avoiding discussions with patients about the reason for their appointment at the reception desk and asking patients on the telephone to hold if a patient approached the reception desk if necessary.

We received 40 completed cards and the majority of these were positive about the service experienced. Patients said they felt the practice offered a good service and both clinical and administrative staff were helpful and caring. They said staff treated them with dignity and respect. The results of the national patient survey showed that 94% of patients found the receptionists at the surgery to be helpful. We also spoke with six patients on the day of our inspection and they told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey 2014 showed that 97% of patients reported that the last GP they saw or spoke to was good at listening to them which was above the CCG average of 84%. Eighty-nine percent of patients felt that the last GP they saw or spoke to was good at involving them in decisions about their care.

During our inspection patients said the GPs involved them in decisions about their care and treatments and this was also reflected in the CQC comment cards we received. We looked at some care plans that had been developed for patients over 75 years of age and found these to be well structured and detailed, for example, information included action plans, falls prevention strategies and key safe arrangements. The practice informed us that patients were given a copy of their care plans to take home.

A telephone interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection were positive about the emotional support provided by staff at the practice and this was reflected in the CQC comment cards we received. Staff told us that if families had suffered a bereavement, they signposted patients if they wished to the practice's counsellor. The counsellor provides weekly counselling sessions for the practice's patients on Wednesday afternoons and early evening. There was an eight week wait to see the counsellor and each session was approximately 50 minutes in duration. Patients would usually have a course of 6-12 sessions, however some patients were offered more as required. In addition to bereavement counselling, the counsellor treated patients

Good

Are services caring?

with depression, anxiety, relationship issues and sexuality orientation and some patients with long term conditions such as Parkinson's disease. The counsellor provided the counselling service on a voluntary basis.

The practice also referred patients to the Improving Access To Psychological Therapies (IAPT) service for treatment of depression or anxiety disorders to help patients experiencing symptoms to seek further care and support.

The practice had a carers identification protocol to identify carers registered with the practice and ensure that they understood the various avenues of support available to them. At the time of our inspection there were 87 patients registered with the practice who had been identified as carers. The practice new patient registration form included questions such as, 'Do you look after someone?' and 'Does someone look after you?' The practice notice board displayed a poster which asked carers to let the practice know about their caring responsibilities.

We also saw posters in the patient waiting room which informed patients how to access a number of support groups and organisations such as the local Carers Centre which is a resource and support centre for all unpaid carers in the borough and offers advice and resource information, holistic therapies, exercise classes and an internet café.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had reviewed the Ealing CCG Local Improvement Scheme (LIS) which sets out strategic objectives to improve outcomes for patients within the local population. The patients we spoke with and those who completed comments cards felt the practice met their healthcare needs and were happy with the service provided.

We reviewed a sample of patient care records and found that people with long term conditions, learning disabilities, dementia and mental health disorders received regular medicines and care plan reviews as required alongside annual reviews of care.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG's work had contributed to the improvement of services and they told us it had improved communication between patients and the practice. For example, changes to appointment system to make it more flexible for patients had been implemented in response to the PPG's suggestions. Patient surveys to obtain feedback on different aspects of care delivery were developed in collaboration with the PPG and undertaken annually.

The practice used a risk profiling software which enabled GPs to identify a range of at-risk patients and detect and prevent unwanted outcomes for patients. The GPs attended multi-disciplinary group meetings every two months with external professionals to discuss the care of patients including those at risk of unplanned admissions and A&E attendances.

There were no male GPs working at the practice however the practice had established arrangements with two neighbouring surgeries with male GPs so patients who requested an appointment with a male GP were able to make an appointment with these surgeries as temporary patients.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice provided GP services to a local hostel for homeless people and worked with them regarding health promotion via a monthly drop-in clinic held at the hostel for residents who declined attendance at the practice. The GPs provided health education talks which included talks on healthy eating, smoking, alcohol, substance abuse and sexual health. We were told that the impact of these talks has been that several residents had stopped smoking, reduced their drinking, improved their diet and had become better educated when forming sexual relationships outside the hostel. The hostel also ensured they had fruit available to residents and encouraged them to take part in exercise activities in the garden.

The practice told us that the health promotion activities at the hostel had improved the relationship between the residents and the practice so they felt happier to attend appointments for health checks as well as specific medical problems. GPs had used this opportunity to educate patients how to use the out of hours facilities and avoid unnecessary A&E attendances.

Tackling inequity and promoting equality

Staff told us that the practice served a population of mixed ethnicities. Some staff members were able to speak additional languages to English including Punjabi and Hindi. The practice could cater for other different languages through the use of a telephone translation and interpreting service. The practice also had a deaf loop system available to assist patients with reduced ranges of hearing.

Staff we spoke with confirmed that they had not completed equality and diversity training but were able to describe various forms of discrimination and recognised the importance of respecting each patient individually.

The practice provided GP services to a local hostel for homeless persons and worked closely with the hostel warden to manage residents with complex mental, social and physical problems. Where appropriate, care plans were developed for residents and their treatment was discussed at multi-disciplinary group meetings. A drop-in clinic was held once a month at the hostel which catered for residents who declined attendance at the practice or the local hospital.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice liaised with key workers and carers of patients with learning disabilities via telephone prior to appointment times to make sure that there was no unnecessary waiting time when they arrived at the practice. The GPs also worked with the local joint health and social service community team for people with learning disabilities if they required additional multi-disciplinary input for learning disabilities patients registered with the practice.

At the time of our inspection the premises and services had not been fully adapted to meet the needs of people with disabilities. For example, there was a ground floor consulting room but the toilet facilities were situated upstairs in the practice and were not functional for disabled use. We saw evidence of the lack of this facility documented in the practice leaflet to inform patients. During our inspection this was discussed with staff and we were informed that the practice were due to have a practice merger and therefore funding support to build a downstairs disabled toilet was not requested. However the merger did not take place and as a result the practice made arrangements to build the new toilet which was in the process of being finished at the time of our inspection and has subsequently been completed.

We saw that the waiting area was large enough to accommodate patients with pushchairs however there were no baby changing facilities available in the practice.

Access to the service

The practice opening hours were between 8.00am - 6:15pm on Mondays, 8:30am - 6:00pm on Tuesdays, 8:30am - 8:00pm on Wednesdays, 8:30am - 1:00pm on Thursdays and 8:30am - 5:00pm on Fridays. GP appointments are available between 9:00am-6:00pm on Mondays, 9:00am-4:00pm on Tuesdays, 9:00am-8:00pm on Wednesdays, 9:00am - 11:00am on Thursdays and 9:00am - 4:00pm on Fridays. There were telephone consultations available daily. During out of hours care was provided through an out of hours provider and patients were also referred to the '111' service.

Patients could book appointments by telephone and in person. Appointments were generally 10 minutes in length however longer appointments were also available for people who needed them and those with long-term conditions. For example, patients with learning disabilities were offered double appointments.

Telephone access was available during core hours and patients were triaged for appointments. According to the national GP survey, 92% of patients reported that they found it easy to get through to the practice by telephone which was above the local CCG average of 70%. For urgent appointments patients were triaged and seen on the same day. The appointment system had availability for urgent appointments each day. For non-urgent appointments patients would be provided with an appointment within 2 weeks. Routine planned visits were also provided for patients with complex needs.

The practice operated a flexible appointment system in order to cater for different patient population groups. Each morning there was an open surgery between 10am - 11am in which patients were offered appointments on a first come first served basis which catered for vulnerable patients such as homeless persons registered with the practice who were not able to contact the practice by telephone for an appointment.

During the months of December to March the practice offered additional winter emergency appointments at 12pm. Appointments for home visits to patients who were housebound were available both morning and afternoon where necessary.

Five appointment slots were available at 10am for mothers with small children so that their consultation could be expedited if necessary. This provision within the practice appointment system was introduced as a result of discussions with the PPG and responses from the practice patient survey and learning from an incident.

Extended hours on Wednesdays each week and the provision of telephone consultations catered for the needs of the working age and student patient population. In response to discussions with the PPG, the practice also changed the morning open surgery appointment system and introduced pre-bookable appointment slots between 9am - 10am to cater for this group. The practice also used a messaging service which sent patients appointment reminders via text message to mobile telephones.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and information on home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

patients telephoned the practice when it was closed, an answerphone message gave information on the out-of-hours '111' service. The practice also provided information on local NHS walk-in centres on the practice website.

Patients we spoke with were happy with the opening hours of the practice. This was reflected in the results of the national patient survey which found that 73 % were satisfied with the opening hours. However, patients we spoke with also told us that they would like the practice to implement an online appointment booking system and an online repeat prescriptions service.

Patients were referred to other services/specialists through on the day referrals by the GP's. The practice did not use the Choose and Book system (the Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital) however patients were given a choice of local hospitals verbally within their consultation.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. It's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The Practice Manager was the designated responsible person who managed all non-clinical complaints and GPs managed all clinical complaints in the practice.

We saw that the complaints procedure was detailed within the practice leaflet and on the practice website to help patients understand the complaints system. The practice had a complaints policy and maintained a complaints log.

We looked at the complaints spreadsheet log for the last 12 months which recorded complaints received verbally, via email and in writing. We reviewed the three complaints received and found that these were appropriately handled. The practice patient survey identified that 66% of patients were unaware of the complaints process. In response to this issue, the practice developed an internet blog explaining the complaints process, provided information on the practice website and created a link to the process on the practice social media page.

The practice reviewed complaints annually to detect themes or trends. We looked at the complaints log for the last year and themes identified included the registration process, waiting times and clinical procedures. Lessons learned and actions taken in response to the complaints received were documented and we saw practice meeting minutes to evidence complaints being discussed and shared with staff. During our inspection we spoke with three members of the practice PPG who informed us that complaint themes were discussed in the PPG meetings.

An example of learning as a result of a patient complaint related to a patient receiving a 'Did Not Attend' (DNA) letter for not attending an appointment made at the practice. The patient complained that she had cancelled her appointment with reception staff and felt that the style of the DNA letter was reprimanding and provided some suggestions to change the wording of the letter. In response to the complaint, the practice manager apologised for the error made by the reception team and accommodated the patient's suggestions and changed the format of the DNA letter. The practice staff were made aware of the complaint and discussed the importance of cancelling appointments immediately following a patient's request. We reviewed the complaints log following this complaint and identified that this complaint issue had not subsequently been repeated.

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 treat patients as individuals, to maintain the traditional doctor-patient relationship in General Practice and promote one-to-one care in a personalised and friendly environment. We found details of the vision displayed in the practice and on the practice website.

Staff we spoke to told us that the practice aims included being as accommodating as possible for patients and providing good services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a hard copy folder held in reception and on the shared drive. The practice had a system in place for the review and dissemination of policies. The practice manager reviewed all policies annually or sooner if required and any updates were circulated via email to staff to keep them informed. Staff were required to respond back to the practice manager to confirm that they had read the policies. All of the ten policies and procedures we looked at had been reviewed annually and were up to date.

We spoke with four members of staff and they were all clear about their own roles and responsibilities. There was no formal leadership structure documentation developed indicating these roles, however staff we spoke with were able to identify named members of staff in lead roles such as safeguarding and infection control. Staff told us they felt well supported, there was strong leadership in the practice and that the management team were approachable to discuss any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The overall QOF score for this practice for 2013/14 showed it had performed 6.1% above the local CCG average and 6 .2 % above the England average. QOF data was discussed at monthly clinical meetings to monitor progress with targets.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. The practice accessed an external agency to provide health and safety risk assessments. We saw evidence of these health and safety risk assessments where identified risks were logged in a risk assessment table. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

Leadership, openness and transparency

The practice had a programme for meetings. Practice meetings were held every two months, clinical meetings were held monthly and multidisciplinary group meetings were attended by clinical staff every two months. The GPs also met weekly to discuss clinical guidelines. Practice meetings were minuted and stored on the computer shared drive however we found that not all clinical meetings were formally documented.

We spoke with four staff members who were clear on their level of responsibility and who to report to with any concerns. Staff told us there was an open culture within the practice and they were supported in their job role.

The practice manager was responsible for human resource policies and procedures. Policies such as appraisal, recruitment and absence were in place to support staff. We were shown the employee handbook that was available to all staff, which included sections on harassment and bullying at work. The practice also had a whistleblowing policy which was available to staff in a hard copy folder held in reception and on the shared drive. Staff were aware of the whistleblowing policy if they wished to raise any concerns and were able to describe circumstances in which they would use it. Staff we spoke with knew where to find all of these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the Friends and Family Test (a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) suggestions, and complaints received. We looked at the results of the practice internal survey 2014 which was commissioned in order to improve patient care and 34% of patients said that they were not aware of the practice's complaints policy and how to make a complaint. As a result of this feedback, one of the GP partners posted complaints

Are services well-led?

Good

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

information via an online blog and this was published on the practice's website and social media page to increase patient awareness. Staff and members of the PPG we spoke with provided examples of other improvements that had been made to the practice as a result of patient feedback which included re-decoration and new flooring in the waiting area.

The practice had an active patient participation group (PPG) of approximately ten members. During our inspection we met with three PPG members who informed us that the PPG was representative of the ethnic population served by the practice but that the group did not have membership of younger generation patients. The practice told us that they would have liked to have representation from the 16-24 age group but had found it challenging to engage this cohort of patients in the PPG. To address this issue the practice had posted on the practice website that if a patient could not attend a PPG meeting but would still like to contribute some ideas for topics discussion, these could be emailed to the practice manager or put in writing. Patients who submitted comments for discussion at the PPG were sent copies of the meeting minutes.

The PPG met every quarter and was attended by a GP and some practice staff. Three of the PPG members we met during our inspection told us that the PPG worked with the practice in the development of the questions for the practice internal patient survey. The results and actions agreed from this survey were discussed with the PPG and were available on the practice website. We saw a list of actions that was developed as a result of the patient survey and we saw evidence of actions that had been carried out.

The practice had gathered feedback from staff through practice meetings and appraisals. Staff told us their managers were approachable and they felt comfortable to give feedback and discuss any concerns or issues. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff appraisals and saw that regular appraisals took place which identified areas for development with timescales for achieving these. Staff we spoke to told us that their appraisals were effective in monitoring their development.

Staff told us that the practice was very supportive of training and development. Administrative staff told us the practice manager informed the team of training courses available and they were currently being supported to complete a National Vocational Qualification (NVQ) in information technology. One administrative staff member told us that she was also being supported to undertake an English and Mathematics training course.

The practice had completed reviews of significant events and other incidents which included lessons learned. We saw evidence that significant events were discussed at practice meetings and the lessons learned were shared with staff to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 19 HSCA (RA) Regulations 2014** **Fit and proper persons employed** How the regulation was not being met: People who use services were not fully protected against the risks associated with the recruitment of staff, in particular in the recording of recruitment information and in ensuring all appropriate pre-employment checks are carried out or recorded prior to a staff member taking up post. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.