

Dr Alan Samuel Muir Grasse

Quality Report

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Date of inspection visit: 11 December 2014

Date of publication: 08/05/2015

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 | Inadequate |  |
| Are services safe? | Inadequate |  |
| Are services effective? | Inadequate |  |
| Are services caring? | Requires improvement |  |
| Are services responsive to people's needs? | Inadequate |  |
| Are services well-led? | Inadequate |  |

Summary of findings

Contents

Summary of this inspection

| | Page |
|---|------|
| Overall summary | 2 |
| The five questions we ask and what we found | 4 |
| The six population groups and what we found | 6 |
| What people who use the service say | 9 |
| Areas for improvement | 9 |

Detailed findings from this inspection

| | |
|--|----|
| Our inspection team | 10 |
| Background to Dr Alan Samuel Muir Grasse | 10 |
| Why we carried out this inspection | 10 |
| How we carried out this inspection | 10 |
| Detailed findings | 12 |
| Action we have told the provider to take | 21 |

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Alan Samuel Muir Grasse on 11 December 2014. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, well-led, effective and responsive services. We found the practice to require improvement for providing a caring service.

We also found the practice to be inadequate 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), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For

example, at the time of our inspection, the practice did not have sufficient drugs or equipment to be able to deal with medical emergencies. At the time of our inspection, the practice did not have an oxygen cylinder;

- There was insufficient assurance to demonstrate people received effective care and treatment. Patient outcomes were at or below average for the locality in a range of clinical areas including diabetes management, chronic kidney disease and cervical screening;
- The practice had limited formal governance arrangements;
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

The areas where the provider must make improvements are:

- Ensure that there is a clear policy and process to address the needs of patients with long term conditions;

Summary of findings

- Undertake a review of patients on chronic disease management registers, triggered by the marked variance between practice and locality QOF performance;
- Introduce a system for monitoring patient outcomes (including use of clinical audits) and take action to improve patient outcomes;
- Undertake a risk assessment of how the practice responds to emergency medical situations;
- Ensure that an oxygen cylinder is on site to be able to deal with medical emergencies;
- Ensure that arrangements are in place to be able to identify and act on patients' concerns;
- Ensure that all non clinical staff are up to date regarding cardio-pulmonary resuscitation (CPR) training.
- Implement systems for sharing learning from significant events and complaints;
- Undertake a review of cervical screening performance triggered by the marked variance between practice and locality QOF performance (45% of women had a record of a cervical smear test within the last five years compared with the Camden practice average of 75%).

The areas where the provider should make improvement are:

- Formally document multidisciplinary team meetings so that these can be used to monitor and improve patient outcomes as necessary;
- Arrange chaperone training for the practice manager;
- Consider the arrangements for dealing with medical emergencies;

- Ensure that the practice website allows patients to request repeat prescriptions;
- Ensure that it is made clear to all patients how they should access services at all times that the surgery is closed during their contracted hours of 8.00am to 6.30pm.
- Introduce a formal system for listening and acting on staff feedback.

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

The practice is rated as inadequate for providing safe services as there are areas where improvements must be made. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, there were insufficient systems to enable lessons to be shared and improvements brought about. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. At the time of our inspection there was no policy setting out how the practice would respond to medical emergencies. The practice did not have sufficient drugs or equipment to be able to deal with medical emergencies. It did not have an oxygen cylinder. A risk assessment had not been undertaken.

Inadequate



Are services effective?

The practice is rated as inadequate for providing effective services as there are areas where improvements must be made. Data showed a confusing picture with respect to patient outcomes. Many were at or below average for Camden CCG in a range of clinical areas including for diabetes management, chronic kidney disease and the diagnosis of hypertension. Knowledge of and reference to national guidelines were inconsistent. We saw no evidence of actions being taken to improve patient outcomes. We noted that one clinical audit had taken place in 2014. However, it was unclear how the audit results had been used to drive improvement in patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

Inadequate



Are services caring?

The practice is rated as requires improvement for providing caring services as there are areas where improvements should be made. Whilst patients we spoke with on the day and comment cards were generally positive about the care they received, only 59% of patients who responded to the national GP survey felt that the GP treated them with care and concern. Only 64% felt that they had been involved in decisions about their care and patient satisfaction was lower than other Camden practices regarding overall patient experience and regarding doctors' ability to treat staff with care and concern. We saw that staff treated patients with kindness and respect and maintained confidentiality.

Requires improvement



Summary of findings

Are services responsive to people's needs?

The practice is rated as inadequate for providing responsive services as there are areas where improvements must be made. Patients told us that access to a named GP (and therefore continuity of care) was usually available. This included urgent same day appointments. However the practice had times that it was closed during its contracted hours of opening 8:00am to 6.30pm. Whilst a telephone answerphone directed patients to an out of hours service, this was not well advertised and not displayed on the practice web site.

The practice was physically equipped to treat patients and meet their needs. However we observed that it could be difficult to access the building using a mobility scooter, wheelchair or pushchair. The practice told us that patients with double pushchairs regularly used the practice without difficulty. Patients could get information about how to complain in a format they could understand. However we only saw one example of a complaint from January 2013.

The practice's senior GP and most regularly used GP locum were male. We were told that female GP locums were occasionally employed but saw no evidence that the needs of female patients had been considered or addressed; through for example a protocol for situations where a patient required prompt access to a female doctor. The practice did not employ a practice nurse. All patients requiring nursing and health visiting services were directed to a local health centre. Patients requiring blood tests were referred to a local hospital.

Inadequate



Are services well-led?

The practice is rated as inadequate for being well-led as there are areas where improvements must be made. The senior GP outlined a vision and strategy for the practice but staff were not aware of their responsibilities in relation to it. We were told that governance matters were discussed at monthly staff meetings but these were not minuted. The practice did not have a formal system for identifying and acting on patient feedback. For example, the Patient Participation Group had not met since 2011 and the practice had considered but had decided not to respond to negative patient comments posted on NHS Choices. Staff received annual appraisals but these were informal and not documented.

Inadequate



Summary of findings

The six population groups and what we found

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

Older people

The provider was rated inadequate for the domains of safety, effectiveness, responsiveness and well led; and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of older people. Care and treatment of older people did not always reflect current evidence-based practice. Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed. For example, although all patients diagnosed with dementia had had a review in the preceding 12 months; only 33% of patients aged sixty five and older had received seasonal flu vaccination (compared with a Camden practice average of 77%). Longer appointments and home visits were available for older people when needed and this was acknowledged positively in patient feedback. Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance (including the Mental Capacity Act 2005).

Inadequate



People with long term conditions

The provider was rated inadequate for the domains of safety, effectiveness, responsiveness and well led; and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people with long-term conditions. We noted that nationally reported data showed that patient outcomes for conditions such as diabetes, chronic kidney disease and mental health were below Camden practice averages. The relatively small number of patients with a long term conditions meant that single incidents such as an unplanned hospital admission could have a disproportionate impact on overall patient outcome performance. Overall however, there was no evidence of action being taken to improve outcomes for patients with long term conditions. For example, although the practice held a long term condition register and patients had a named GP, patient reviews appeared opportunistic. The senior GP worked with other health care professionals such as district nurses to deliver a multidisciplinary and coordinated package of care although we noted that these meetings were not minuted.

Inadequate



Summary of findings

Families, children and young people

The provider was rated inadequate for the domains of safety, effectiveness, responsiveness and well led; and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of families, children and young people. Childhood immunisation rates at twelve months, twenty four months and five years were generally better than the average for Camden practices. However, there was no evidence of systems in place to follow up missed appointments. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this such as appointment availability outside of school hours. However, we also noted that the premises were not suited for families, children and young people. The practice entrance was not wheelchair accessible and some corridors were too narrow to manoeuvre a push chair. We also noted that baby changing facilities were not available.

Child immunisation were undertaken by the GPs at the surgery but without access to all equipment to deal with medical emergencies.

Inadequate



Working age people (including those recently retired and students)

The provider was rated inadequate for the domains of safety, effectiveness, responsiveness and well led; and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. Although the practice offered extended opening hours until 6.30pm for appointments from Monday to Friday, there were no early opening hours for working people and patients could book appointments on line but not order repeat prescriptions. Health promotion advice was offered on the practice website and throughout the practice. We noted that there was a low take up of health checks and health screening compared to the Camden practice average. For example, only 45% of women had a record of a cervical smear test within the last five years; compared with the respective Camden and England practice averages of 75% and 72%. We noted limited evidence of action being taken to improve this patient outcome.

Inadequate



Summary of findings

People whose circumstances may make them vulnerable

The provider was rated inadequate for the domains of safety, effectiveness, responsiveness and well led; and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate 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.

Staff were aware of various support groups and voluntary organisations for vulnerable people. They knew how to recognise signs of abuse in vulnerable adults and children. Staff were also aware of their responsibilities regarding information sharing, documenting safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice offered interpreting services in a range of languages including British Sign Language (BSL). We noted that 10% of patients had a caring responsibility.

Inadequate



People experiencing poor mental health (including people with dementia)

The provider was rated inadequate for the domains of safety, effectiveness, responsiveness and well led; and requires improvement for caring services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). Only 37% of people experiencing poor mental health had had a cholesterol check within the preceding twelve months and only 45% had had their body mass index recorded. This compared with the respective Camden and England practice averages of 69% and 82%. There was no evidence of action being taken to improve patient outcomes.

There was evidence that the practice had systems in place to support patients presenting with acutely poor mental health and also to signpost patients with less severe symptoms to specialist local voluntary sector organisations. However, we also noted that the practice's performance on new diagnoses of depression, which had had a review not later than the target 35 days after diagnosis, was below the practice averages for Camden and England.

Inadequate



Summary of findings

What people who use the service say

During our inspection, we spoke with four patients who were positive about the care and treatment they received and about the practice environment. We also reviewed two patient comment cards which had been completed by patients in the two week period before our inspection and enabled patients to record their views on the practice. Feedback was positive regarding staff attitudes, the practice environment and how treatments were explained.

We also reviewed NHS England GP national patient survey 2014 (72 respondents) and noted that 89% of

patients described their experience of making an appointment as good (compared with the Camden practice average of 69%). The survey also feedback that 91% of respondents felt that it was easy to get through to the practice by phone (compared with the Camden practice average of 77%). However, we also noted that only 64% of patients felt that the last GP they saw was good at explaining treatments (compared with a Camden practice average of 84%). Also, only 56% of respondents would recommend the practice to someone new to the area (compared with a Camden practice average of 77%).

Areas for improvement

Action the service **MUST** take to improve

- Ensure that there is a clear policy and process to address the needs of patients with long term conditions;
- Undertake a review of patients on chronic disease management registers triggered by the marked variance between practice and locality QOF performance;
- Introduce a system for monitoring patient outcomes (including use of clinical audits) and;

take action to improve patient outcomes;

- Undertake a risk assessment of how the practice responds to emergency medical situations;
- Ensure that an oxygen cylinder is on site to be able to deal with medical emergencies;
- Ensure that arrangements are in place to be able to identify and act on patients' concerns;
- Ensure that all non clinical staff are up to date regarding cardio-pulmonary resuscitation (CPR) training.

- Implement systems for sharing learning from significant events and complaints;
- Undertake a review of cervical screening performance triggered by the marked variance between practice and locality QOF performance (45% of women had a record of a cervical smear test within the last five years compared with the Camden practice average of 75%).

Action the service **SHOULD** take to improve

- Formally document multidisciplinary team meetings so that these can be used to monitor and improve patient outcomes as necessary;
- Arrange chaperone training for the practice manager;
- Consider the arrangements for dealing with medical emergencies;
- Ensure that the practice website allows patients to request repeat prescriptions;
- Ensure that it is made clear to all patients how they should access services at all times that the surgery is closed during their contracted hours of 8.00am to 6.30pm. Introduce a formal system for listening and acting on staff feedback.

Dr Alan Samuel Muir Grasse

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector** and a GP Specialist Advisor.

Background to Dr Alan Samuel Muir Grasse

Dr Alan Samuel Muir Grasse (known as West End Lane Medical Practice) is located in Camden, North London and has a patient list of approximately 1,400 (one of the smallest in Camden). The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients.

Twenty two percent of patients are aged 65 or older and 12% are under 18 years old. Forty five percent have a long standing health condition and 10% have carer responsibilities.

The services provided include child health care, ante and post natal care, immunisations and management of long term conditions. The staff team comprises one senior GP (male), four GP locums (one male, three female), practice manager and two part time administrative staff.

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

Public Health England's Camden 2014 Health Profile notes that the health of people in Camden is varied compared

with the England average. Deprivation is higher than average and about 32.5% (10,800) children live in poverty. Life expectancy for both men and women is higher than the England average. Life expectancy is 12 years lower for men and 10 years lower for women in the most deprived areas of Camden than in the least deprived areas.

Regarding child health, 21.8% of ten year olds are classified as obese (worse than the average for England). Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are better than the England average.

Regarding adult health, in 2012, 13.7% of adults were classified as obese (better than the average for England). The rate of self-harm hospital stays was 86.2, better than the average for England. Rates of sexually transmitted infections and TB are worse than average.

In Camden, strategic improvements in health and wellbeing are led by the borough's Health & Wellbeing Board; comprised of Camden Council, Camden CCG, Camden Healthwatch and other health stakeholders. Priorities include tackling obesity, providing better health outcomes for families with complex needs and reducing harm caused by alcohol.

Why we carried out this inspection

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

Detailed findings

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 December 2014. During our visit we spoke with a range of staff (senior GP, practice manager and receptionist) and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe Track Record

Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff knew their roles and accountability in this process. There were effective arrangements in place to report safety incidents in line with national and statutory guidance.

The practice had a safety alert procedure to ensure that national drugs safety alerts received were shared with all staff at the practice. Staff knew their roles and responsibility under this procedure. For example, the practice manager outlined their role in acting on alerts received from Camden Clinical Commissioning Group (CCG), ensuring that printed copies of the alerts were placed on file.

Learning and improvement from safety incidents

The practice had limited systems in place for reporting, recording and monitoring significant events. We noted that three significant events had been logged since August 2012. They included a record of the area of concern, individual staff learning point and key actions undertaken. For example, following an incident where a patient fell outside reception, the practice reviewed the status of emergency medical training for all staff. However, we noted that there was no evidence of shared team learning from significant events or of a significant events policy outlining how this should happen, so that staff understood and fulfilled their responsibilities to raise concerns and report incidents or near misses.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. The senior GP was designated safeguarding lead and the practice had ensured all staff were trained to the appropriate level in protecting vulnerable adults and children from abuse. For example, the senior GP was Level 3 trained in child protection and non clinical staff had attended basic children and vulnerable adults safeguarding training. Staff were able to recognise types of abuse (including in older patients) and knew how and to whom they would report or escalate a concern. The practice had policies for child protection and vulnerable adults which included local authority and CCG contact details. Staff were aware of these contacts.

The practice had a chaperone policy and we were told that the practice manager undertook chaperoning duties. They had undergone Disclosure and Barring Service (DBS) checks but had not received chaperone training. There were no other female staff who could undertake chaperoning duties. Both the senior GP and main locum GP are male.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients experiencing poor mental health.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures. This also included action to take in the event of a power failure. We noted that medicines refrigerator temperatures were recorded on a daily basis and were within the required parameters. Medicines were within their expiry date. We did not see any evidence of medications audits triggered by NICE guidance.

The practice did not hold Controlled Drugs on the premises.

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 & Infection Control

Patients were treated in a clean, hygienic environment. All communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment. Consultation rooms had vinyl flooring and we noted that clinical waste was stored securely away from patient areas whilst awaiting collection. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice manager was the Infection Prevention and Control (IPC) lead and responsible for ensuring effective

Are services safe?

infection control throughout the practice. They had attended infection control training within the last twelve months. Personal protective equipment such as gloves and aprons were readily available for staff to use.

The practice had an infection control policy and we noted that in accordance with the policy, infection control audits took place every six months. We looked at the latest audit results (September 2014) and were able to confirm for example that in accordance with the audit action plan, sharps bins were signed and dated.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had also taken place within the last two years and we noted that no issues had been identified. Records confirmed the practice was carrying out regular checks in line with its legionella policy to reduce the risk of infection to staff and patients.

Equipment

We saw evidence of calibration of relevant equipment within the last twelve months including electronic blood pressure machines and weighing scales. Fire alarm and portable appliance testing (PAT testing) had also taken place within the last twelve months.

Staffing & Recruitment

The practice had systems in place to ensure that staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had recruitment procedures in place that ensured staff were recruited appropriately. The majority of staff had been employed by the practice for several years. Disclosure and Barring Service (DBS) background checks were on file for clinical and non clinical staff. Staff told us there were usually enough staff to maintain the smooth running of the practice and we saw evidence that systems were in place to keep patients safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual, bi-annual and

monthly checks of the building and equipment, infection control, medicines management, staffing and dealing with emergencies. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

We noted that the practice had taken action regarding some risks (such as the findings from the latest infection control audit) but there was no evidence of any formal risk management meetings having taken place.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. They gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

We also noted that the practice monitored repeat prescribing for people experiencing poor mental health. For example, the senior GP told us that it was practice policy not to repeat prescribe anti-psychotic drugs for more than four weeks so that dosage could be monitored and possible risks managed.

Arrangements to deal with emergencies and major incidents

At the time of our inspection there were insufficient systems in place to deal with medical emergencies. We noted that the practice held a limited range of emergency drugs and we were told that these were deemed sufficient by the practice to deal with medical emergencies arising from complications relating to administering childhood vaccinations. However, there was no evidence of a written risk assessment identifying a list of emergency medicines that were not suitable to stock or an assessment of the emergency services available to them.

For example, we were told that the provider did not have a supply of emergency oxygen or an emergency automated defibrillator (AED). The risks of not having oxygen or AED had not been assessed. We advised the practice of our concern and shortly after our inspection, we were advised that additional emergency drugs to cover foreseeable medical emergencies had been purchased and systems put in place for regularly checking that they were within their expiry date. We were also told that the practice had a supply of emergency oxygen on its premises.

We noted that the medication that was available was within expiry date and that the practice had a system for regularly checking that medication was within expiry date.

Are services safe?

At the time of our inspection, we noted that the senior GP had received cardiopulmonary resuscitation (CPR) training within the last twelve months and that non clinical staff had received CPR training within the last three years.

The practice had a business continuity plan which described to staff what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure, and contained relevant

contact details for staff to refer to (such as support numbers in the event of an electrical power failure). If the practice had to close urgently, we noted that there was a reciprocal arrangement in place with a nearby practice which used the same clinical system. The plan had been reviewed in the last twelve months and we noted that staff understood their roles and responsibilities.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had limited systems in place to ensure that patients' care and treatment was assessed, planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There was some evidence that the senior GP was familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) for example regarding asthma and lung disease. However, there was no evidence of clinical meetings having taken place with the senior GP and locum GPs where guidelines were disseminated, implications for the practice's performance discussed and required actions agreed. We noted that the practice's QOF performance on patient assessments and reviews for most clinical areas were below the Camden practice average.

Management, monitoring and improving outcomes for people

The practice had limited systems in place to monitor patient outcomes. For example, we were told that the senior GP led on QOF monitoring and that clinical meetings did not take place. We noted that one clinical audit had taken place in 2014 regarding the prevalence of hypertension. However, it was unclear how the audit results had been used to drive improvement in patient outcomes.

We noted that the practice collected quality and outcomes framework (QOF) data. QOF is national performance measurement tool. However, there was also no evidence that the practice used QOF data to monitor and improve patient outcomes as necessary. Additionally, we noted that the practice was not involved in local CCG benchmarking activity; where performance could be compared and evaluated against similar sized surgeries. Consequently, when we looked at practice performance data, we noted that with the exception of childhood immunisations, most patient outcomes were either at or below average for the locality.

For example, QOF data showed that only 62% of diabetic patients had had a foot examination in the previous twelve months compared with the Camden practice average of 85%. We also noted that at 45%, the practice performed worse than the Camden (61%) and England (62%) practice averages for newly diagnosed patients with depression

who had had a follow up review within the target 35 days. We noted that the prevalence of hypertension appeared to be very low and this has been confirmed following our inspection.

We also looked at the practice's performance on care of patients with diabetes. Patients with diabetes have high blood glucose (sugar levels) which over time can cause a range of problems including kidney disease. The practice's QOF performance showed that only 3% of patients with diabetes had been tested for early signs of kidney disease in the last 15 months; compared with the Camden practice average of 83%. There was no written evidence of action being taken to improve these or other patient outcomes.

We looked at the records of seven patients with diabetes and identified concerns with two records regarding frequency of medicines review. The records for five of the seven records appeared to be satisfactory. The practice told us that they had been unable to contact the two patients because up to date contact details were not available and they thought that the patients must have moved to a different area but had not yet registered with a new practice.

Effective staffing

Practice staffing included medical and administrative staff. Staff training records showed that all staff were up to date regarding mandatory training (for example safeguarding). The senior GP was up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation in March 2014. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had completed annual appraisals within the last 12 months where performance was reviewed and training needs identified. They told us that although formal supervision meetings did not take place, they felt supported in their roles.

We noted that the practice had a system in place whereby the locum GPs left handover notes for the senior GP. We also noted that referral letters were not despatched until

Are services effective?

(for example, treatment is effective)

they had been quality assured by the senior GP. Whilst it was the GPs stated practice to monitor all referrals made by the locum GPs, it was not clear what processes were in place should the GP be on leave or unavailable for a period of time.

Working with colleagues and other services

The practice had some systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. Multidisciplinary working was taking place with district nurses and health visitors but was generally informal. None of the meetings were minuted and there was no way of checking to see if actions had been delivered or not. Systems were in place to refer patients to specialist third sector agencies including mental health and carer support. We noted the practice had a system in place whereby long term locum GPs left a hand over note for the senior GP; advising him of any urgent patient safety matters. This system appeared to be ad hoc and did not give confidence that all important information would be passed between the two GPs.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. When we reviewed the system we saw that patients were referred in a timely manner and that all the information needed for their ongoing care was shared appropriately. We were told that incoming correspondence was processed in a timely fashion. We were also told that when the senior GP returned from annual leave they routinely reviewed the notes of the locum GPs to assess the completeness of records and identify action to be taken where necessary.

Consent to care and treatment

Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005 the Children Acts 1989 and

2004. The senior GP understood the key parts of the legislation and were able to describe how they implemented it in their practice. Systems were in place to support patients to make decisions including where appropriate, an assessment of their mental capacity. Systems were also in place for situations where patients lacked the mental capacity; ensuring that 'best interests' decisions were made and recorded in accordance with legislation.

The senior GP also demonstrated an understanding of Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

The practice operated a limited range of range of health promotion activity. We were told that patients seeking ante natal clinics, sexual health clinics and smoking cessation were referred to a local health centre where these services were offered. The practice did offer a full range of immunisations for children and flu vaccinations in line with current national guidance. For example, we noted that performance on childhood immunisations at twelve months, twenty four months and five years was broadly above the Camden practice average. However, the performance for flu vaccination was poor at 33% for patients over 65 and was significantly below the Camden practice average of 72%. No consideration appeared to have been given as to how to improve this.

We also noted that only 59% of diabetic patients had had a dietary review in the last twelve months (below the Camden practice average of 86%).

Performance data on women who had had cervical screening within the last five years (45%) was also worse than the practice averages for Camden and England (respectively 72% and 77%). No consideration appeared to have been given as to how to improve this.

We noted that the reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health. However, in spite of this the recording of patients with hypertension appeared to be very low.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Before our inspection, we noted NHS England 2014 national GP patient survey feedback that 95% of respondents found receptionists helpful. When we spoke with patients they were positive about how they were treated by reception staff. During our inspection, we observed that reception staff treated patients with dignity and respect. Patients spoke positively about how they were treated by GPs and nurses and we noted that this was also consistent with comment card feedback. When we asked the receptionist what they had learned from customer care training they had attended, they stressed the importance of good communication skills.

We noted that the national patient survey showed that 78% of patients felt that the GP they saw or spoke to was good at listening to them and that 72% felt that the last GP they spoke with was good at giving them enough time.

We also noted the NHS England 2014 national GP patient survey showed that only 59% of respondents felt that their GP treated them with care and concern. The practice offered a chaperone service which was publicised in reception. The practice manager undertook chaperone duties and had been DBS checked but had not received chaperone training.

During our inspection, we observed that the reception area was located adjacent to the waiting room and that conversations between the receptionist and patients could be overheard. However, privacy in reception was not identified as an issue in the NHS England 2014 national GP patient survey or in face to face or comment card feedback.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that they felt involved in decisions about their care and treatment including some involvement in care planning. However, although the NHS national patient survey reported that 78% of respondents felt their GP was good at listening, only 64% felt that they were good at involving them in decisions about their care.

We noted that the practice website and reception contained a range of information to help patients make informed decisions about their care and treatment including information on smoking cessation, child immunisation and physical activity.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website advised people how to access local and national support groups and organisations. Patients told us that staff responded compassionately and provided support when required such as during times of bereavement or prolonged treatment.

The practice signposted patients to organisations providing specialist support such as cancer and diabetes support. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked. We noted that 10% of patients had a caring responsibility. Patients we spoke with were positive about staff compassion. For example, one patient told us that staff were particularly supportive during a time of bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a named GP and extended appointment slots for patients aged over 75 years or who had a learning disability. Home visits were also available as well as telephone consultations. We were told that patients requiring baby clinic, sexual health clinics and smoking cessation were referred to a local health centre. There had been very little turnover of staff during the last five years which enabled good continuity of care.

We were told that the practice's Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice) had not met for more than two years and that there were no immediate plans to convene a meeting. This meant that the practice did not have a forum for hearing patient views and for feeding back how it had acted on them. We noted that the last patient survey took place in 2011 and there was no evidence of how the practice had acted upon the results of the 2014 NHS national GP survey. We noted that the three highest ranking patient concerns were the GPs' ability to explain tests, treat patients with concern and overall satisfaction (represented as patient recommendation).

We noted shortfalls in how the needs of different people were taken into account. For example, there were two male GPs working at the practice (the senior GP and the main locum GP). However, although we were told that the practice occasionally used female GP locums, we did not see a protocol outlining what would happen if a patient wanted to be seen by a female GP.

Services were delivered in a way that did not meet the needs of patients. For example, the practice did not employ a practice nurse and we were advised that patients requiring a cervical smear test or baby clinic were referred to a local health centre. We noted that this was potentially discriminatory towards women and parents. Patients requiring a blood test were referred to a local hospital.

Tackling inequity and promoting equality

The practice was located in a converted house. The practice was not wheelchair accessible and there were no arrangements in place for wheelchair users. Toilets were not wheelchair accessible and did not contain baby changing facilities. We observed that it would be difficult to access the building using a pushchair. The practice told us

that patients with double pushchairs regularly used the practice without difficulty. The waiting area was spacious. The practice made use of an interpreter service (including British Sign Language interpreters) to ensure patients whose first language was not English could access the service.

We noted that the practice web site was available in local community languages such as Polish and Somali. We did not see evidence of translated materials in reception such as the practice complaints policy or new patient information leaflet. There was a screen in the waiting area which announced the next patient to be seen, which was responsive to the needs of patients with a hearing impairment.

Access to the service

The practice offered appointments from 09.00am-2pm and 4.30pm-6.30pm Monday to Friday (closed Thursday afternoons). However, at the time of our inspection it was not clear how patients would access services outside these times.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed but we noted that it appeared unclear to patients how they should access GP services in the times that the surgery was closed. For example, if patients called the practice when it was closed, an answerphone message gave the telephone number of an out of hours provider they should ring depending on the circumstances. However, we noted that this out of hours number was not prominently displayed on the practice website. We also noted that the practice website allowed patients to book appointments but did not allow repeat prescriptions to be submitted.

National patient survey results showed that 91% of respondents found it easy to get through to the practice by phone and that 87% usually waited 15 minutes or less to be seen. These figures compared favourably with the Camden practice averages.

Listening and learning from concerns & complaints

We saw that information was available in reception to help patients understand the complaints system. This included advice on how patients could escalate complaints to the Health Service Ombudsman. Patients told us they were aware of the process to follow if they wished to make a

Are services responsive to people's needs? (for example, to feedback?)

complaint but had not needed to make a complaint about the practice. We noted that the complaints section of the website was located under “practice policies” and not easily accessible.

Records showed that only one complaint had been received since January 2013 and that it had an associated

learning outcome which had been shared with staff. However, we did not see evidence of a system of reviewing complaints to identify themes or trends which could be used to improve the service.

Are services well-led?

Inadequate 

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

Our findings

Vision and Strategy

We spoke individually with a range of staff including the senior GP, reception staff and practice manager. Staff outlined a shared vision for delivering good quality and patient centred care although the practice did not have a business plan or strategy. We noted that the senior GP had submitted a succession plan to NHS England proposing a merger with another local practice.

However, when we looked at the plan, we noted that it made limited reference to quality of patient care and no reference to seeking patients' views on the proposals. We were later told that the plan was an early working draft.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We noted that they had been reviewed within the last twelve months. The senior GP and practice manager undertook lead roles in areas such as information governance, infection control and safeguarding and staff demonstrated an understanding of the policies. However, the practice did not have a significant events policy; highlighting what constituted a significant event, the reporting process and how the practice shared learning.

There was no evidence of clinical meetings reviewing QOF performance or of a planned programme of clinical audits to improve outcomes for patients. We were told that monthly team meetings took place where governance and risk issues were discussed but these were not minuted. However, we did note that actions had been taken to minimise infection control risks following a September 2014 infection control audit.

Leadership, openness and transparency

There had been very little turnover of staff during the last five years which enabled good continuity of care. The practice manager told us that although formal team

meetings were infrequent, informal discussions regularly took place. Staff told us that there was an open culture at the practice and that they felt comfortable raising issues outside of formal team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place to support staff such as the staff induction and whistleblowing policies. We were shown the electronic staff handbook that was available to all staff, which included these and other policies to support staff such as harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice's last annual patient survey took place in 2011 and we were also advised that the practice PPG had not met since this time. This meant that the practice did not have a formal system in place for identifying and acting on patient feedback. We also noted that the practice had considered but had decided not to respond to negative patient comments posted on NHS Choices regarding staff attitudes and the practice environment

There was evidence that the practice sought and received staff feedback but we noted that this was informal and not minuted. The practice manager told us that because the staff team was small, matters could easily be discussed and that she had an "open door policy." Staff confirmed that they felt comfortable proposing suggestions on how the practice was run and also felt involved in decision making.

Management lead through learning & improvement

The senior GP outlined how they maintained their clinical professional development through for example protected learning time, review of medical journals and on line e-learning. Administrative staff told us that the practice was very supportive of training. Staff told us that annual appraisals took place but that these were informal and not documented. There was limited evidence of how learning from significant events and complaints was shared and used to improve patient outcomes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|--|
| Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury | <p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014</p> <p>Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The provider did not take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Specifically:</p> <p>There was no evidence that the provider held regular clinical meetings to review patient care;</p> <p>The practice's QOF performance showed that only 3% of patients with diabetes had been tested for early signs of kidney disease in the last 15 months; compared with the Camden practice average of 83%. There was no written evidence of action being taken to improve these patient outcomes.</p> <p>The provider did not undertake a proactive system of regular review of patients on its chronic disease registers (including use of clinical audits);</p> <p>This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The provider did not have appropriate procedures in place for dealing with medical emergencies which are reasonably expected to arise from time to time. Specifically, the practice only stocked emergency drugs relating to an adverse patient reaction to an immunisation.</p> |

Requirement notices

The provider did not have appropriate procedures in place for dealing with medical emergencies which are reasonably expected to arise from time to time. Specifically, the practice did not have an emergency oxygen cylinder on the premises.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

- Diagnostic and screening procedures
- Maternity and midwifery services
- Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014

Good governance

How the regulation was not being met:

The provider did not regularly seek the views of service users and persons acting on their behalf.

Specifically:

An active patient participation group was not in operation, practice surveys had not taken place since 2011 and the provider could not provide recent evidence of how it had listened to and acted upon patients' views.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.