Dr Sunil Mayor

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Sunil Mayor on 8 January and a follow up visit on 3 February 2015. Two visits were carried out as the second of these was to assess compliance with a previously issued Warning Notice. Overall the practice is rated as Inadequate.

Specifically, we found the practice inadequate for providing safe, effective and well-led services. It was also inadequate for providing services for the 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 and People experiencing poor mental health (including people with dementia). It required improvement for providing a caring and responsive service.

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 patient test results were not actioned in a timely manner.
- The practice had ineffective leadership structure, insufficient leadership capacity and limited formal governance arrangements.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Data showed a number of patient outcomes were at or slightly below average for the locality.
- Patients said they were usually able to get same day urgent appointments, however the practice lacked continuity of care and it was difficult to make an appointment with a GP of their choice.
- Most patients felt they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and easy to understand however not all patients were aware how to complain, and not all staff were aware the practice had a complaints book .
- The practice held regular practice meetings for non-clinical staff, however there were no regular meetings involving clinical staff.

The areas where the provider must make improvements are:

- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure patient test results are actioned in a timely manner, and all letters received by the practice relating to patient care are seen by a GP.
- Ensure vulnerable patients, such as those with mental illness or learning disabilities are offered an annual health check.
- Ensure clinical audit cycles are completed and are used to drive improvements in patient care.
- Ensure the practice assesses the risk of, and takes steps to prevent, detect and control the spread of, infections, including providing access to hand washing facilities where tests which carry a high risk of infection are carried out;carrying out infection prevention and control audits; providing in date sterile gloves, ensuring single use equipment is only used once, and ensuring sharps bins are appropriately stored.
- Ensure the proper and safe management of medicines including appropriately signed Patient Group Direction; sufficient quantities of emergency medicines and staff awareness of where these are stored; and that staff responsible for medicine refrigerator temperature checks know what action to take should the thermometer read under or over the recommended temperature.
- Ensure all staff receive training appropriate to their role; that they are enabled to review and understand key policies and procedures such as the whistleblowing policy and induction policy, and they receive appropriate support, professional development, supervision and appraisal.
- Ensure all clinical staff are given the opportunity to be involved in practice meetings for their own support and development, receive relevant practice information including clinical updates and contribute to the improvement of patient care.
- Ensure recruitment practices comply with the regulations.

In addition the provider should:

- Introduce a system for the review of data from audits and QOF to support learning and promote development of the practice.
- Ensure all patients identified as in need of an annual health check are offered one.
- Formalise plans to address patient concerns regarding continuity of care.
- Ensure all repeat prescription requests can be audit trailed for as long as the prescription remains uncollected.
- Implement a system for recording the serial numbers of blank prescription forms issued to which GPs to ensure there is an appropriate audit trail.
- Develop and implement a patient consent policy.
- Translate key information into the prevalent language for the practice population.
- Ensure information on how to complain is easily accessible for patients and that all staff are aware of the complaints book.
- Ensure patient confidentiality is protected by ensuring patients cannot be overheard during treatment and / or consultations.
- Include safeguarding as a standing agenda item for practice meetings.
- Ensure patients are made fully aware of the out of hours service, and information on the out of hours service is consistent across the practice leaflet, website and telephone answer message.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

On the basis of the ratings given to this practice at these inspections, I am placing the provider into special measures. This will be for a period of six months. We will

Summary of findings

inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

Patients were at risk of harm because the practice did not have a safe and effective system in place for the monitoring and actioning of patient test results, and not all letters received by the practice relating to patient care were seen by a GP. Medicine management was not satisfactory. Not all staff had received basic life support training, whilst some staff were unaware of the location of emergency medical equipment and medicines.

The practice had not carried out an infection control audit in the past year. Staff did not have access to sterile gloves that were within their use by date, open 'single use' equipment was found in a drawer and not all sharps bins were appropriately stored.

Information and lessons learnt were communicated to staff via practice meetings. However, most GPs were locums and although we were told the practice manager passed on relevant information to the locum GPs this was not evidenced. There was limited evidence that the clinical lead monitored clinical practices. The clinical lead was unable to tell us if an annual clinical audit had been undertaken in the last 12 months. The practice manager was unable to demonstrate safe recruitment practices. Not all staff felt they had received sufficient training to undertake their role and not all staff felt supported or able to raise concerns.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made. Data showed a number of patient outcomes were at or below average for the locality. We found a high number of test results that had not been actioned. There were no completed clinical audits of patient outcomes and we saw no evidence that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but minutes from these meetings were limited.

There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required. For example the practice nurse had not received an annual appraisal for the clinical aspects of their role, and some staff told us they were asked to carry out work outside of their training.

Summary of findings

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Staff treated patients with kindness and respect. Data showed that patients rated the practice comparable to or slightly higher than others for several aspects of care. However, some patients said they did not always get to see the GP of their choice and did not know how to contact the out of hour's service. Most patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Although the practice did not actively promote its services with homeless organisations, we were told that there were four or five homeless people registered with the practice. The practice could not demonstrate it had effective systems in place to care for all of its patient groups.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population and had engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) it had not put systems in place to ensure it responded to the needs of all its population groups. For example the practice had identified patients with poor mental health however most of these patients had not received regular physical checks. The practice could not confirm how many patients with a learning disability had received an annual health check.

Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand although some patients said they did not know about the complaints procedure. There was limited evidence that learning from complaints had been shared with staff and not all staff were aware the practice had a complaints book. The practice provided information about its out of hour services in a leaflet, on its website and in a telephone answering message however the information was inconsistent across all three mediums.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. Some staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was no effective leadership structure and some staff did not feel supported by management and they did not all feel listened to or able to raise concerns. The practice had a

Summary of findings

number of policies and procedures to govern activity, but these needed to be further embedded to ensure they were known by all staff, particularly those new to the practice. There was limited evidence to demonstrate that regular governance meetings were held and how this information drove improvements. There were inadequate systems in place to monitor and improve quality and identify risk, and it was unclear how the clinical lead monitored clinical practices.

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

Inadequate

The practice is rated as inadequate for the care of older people. The concerns which led to these ratings apply to everyone using the practice, including this population group. Patients over 75 years of age had a named GP and were offered longer appointments and home visits. The practice had in place a system to recognise and support dementia and end of life care however there was no evidence to indicate how effective this system was.

People with long term conditions

Inadequate

The practice is rated as inadequate for the care of people with long term conditions. The concerns which led to these ratings apply to everyone using the practice, including this population group. Longer appointments and home visits were available when needed. The practice had in place a system to minimise unplanned admissions to hospital but had not audited this to see how effective it was. Data showed that the practice achieved outcomes in line with the CCG average in most areas however it was below average for the identification of patients with chronic obstructive pulmonary disease (lung disease) and also for the percentage of patients with diabetes whose blood glucose level had been 64mmol or less in the preceding year (the higher the level the more likelihood of poor control of blood glucose levels).

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The concerns which led to these ratings apply to everyone using the practice, including this population group. Practice hours were organised in a way to accommodate after school appointments and the practice record for child immunisations was comparable with other practices within the local clinical commissioning group (CCG). Ante-natal and post-natal checks were carried out by the principal GP and practice nurse. The principal GP said that they undertook the first four ante-natal shared care checks with hospital based midwives and worked with health visitors in post-natal patient care. Staff told us they had completed appropriate training in safeguarding children, and there was evidence that concerns raised about a child had been acted on appropriately. Children who did not attend appointments were flagged up and where appropriate social services were informed.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people. The concerns which led to these ratings apply to everyone using the practice, including this population group. Opening times allowed for appointments out of working times, however some patients felt weekend opening would help further. The practice website provided appropriate information and enabled online appointment bookings. The practice used text messaging and telephone consultations were also available.

People whose circumstances may make them vulnerable

Inadequate

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 living in temporary accommodation and those with a learning disability. The practice had 16 patients registered with a learning disability but the principal GP did not know how many had been seen for an annual health check. Homeless people could register with the practice and could use the practice address to access other services. Although most staff knew how to recognise the signs of abuse, and we were told that all staff had received relevant training, not all knew whether they had completed this training.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health. Although the practice had identified patients with poor mental health, most of these patients had not received regular physical checks. We noted that there was insufficient structure in the management of patients with poor mental health and / or depression. In addition there was a high rate of patients attending accident and emergency (A&E) services. Although the principal GP had recognised the need to address the high A&E attendance there were no records to support how they were doing this.

Summary of findings

What people who use the service say

We received 33 care quality commission (CQC) patient comment cards, all of which were positive about the service they received. We also spoke with 11 patients on the first day of our inspection visit on 8 January 2015. The practice promoted the 'family and friends test in general practice'.

Patients we spoke with felt that their privacy and confidentiality was respected. Patients said consultation / treatment doors were always closed and carers who were also family members told us that when they attended appointments for themselves other family members' health was never discussed.

Patients said that the GPs explained all conditions and treatments in a way that was clear and understandable.

Some patients told us that they did not always get to see the GP of their choice and felt continuity of care could be improved.

Most patients were happy with the opening times but some patients felt weekend opening would be helpful to them. Some patients did not know how to contact the out of hours service and some felt there was limited information available regarding the specialist clinics available at the practice.

The National Patient Survey 2015 indicated patients rated the practice above the CCG average for ease of getting through by phone; being involved by the nurse in decisions about their care and for the GP giving them enough time. The practice achieved below CCG average for patients being able to see their preferred GP; for getting an appointment and for the length of time they waited after their appointment time.

Most patients were aware of the complaints process and felt it was accessible.

Areas for improvement

Action the service MUST take to improve

- Clarify the leadership structure and ensure there is leadership capacity to deliver all improvements.
- Ensure patient test results are actioned in a timely manner, and all letters received by the practice relating to patient care are seen by a GP.
- Ensure vulnerable patients, such as those with mental illness or learning disabilities are offered an annual health check.
- Ensure clinical audit cycles are completed and are used to drive improvements in patient care.
- Ensure the practice assesses the risk of, and takes steps to prevent, detect and control the spread of, infections, including providing access to hand washing facilities where tests which carry a high risk of infection are carried out;carrying out infection prevention and control audits; providing in date sterile gloves, ensuring single use equipment is only used once, and ensuring sharps bins are appropriately stored.
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- Ensure all clinical staff are given the opportunity to be involved in practice meetings for their own support and development, receive relevant practice information including clinical updates and contribute to the improvement of patient care.
- Ensure recruitment practices comply with the regulations.

Summary of findings

Action the service SHOULD take to improve

- Introduce a system for the review of data from audits and QOF to support learning and promote development of the practice.
- Ensure all patients identified as in need of an annual health check are offered one.
- Formalise plans to address patient concerns regarding continuity of care.
- Ensure all repeat prescription requests can be audit trailed for as long as the prescription remains uncollected.
- Implement a system for recording the serial numbers of blank prescription forms issued to which GPs to ensure there is an appropriate audit trail.
- Develop and implement a patient consent policy.
- Translate key information into the prevalent language for the practice population.
- Ensure information on how to complain is easily accessible for patients and that all staff are aware of the complaints book.
- Ensure patient confidentiality is protected by ensuring patients cannot be overheard during treatment and / or consultations.
- Include safeguarding as a standing agenda item for practice meetings.
- Ensure patients are made fully aware of the out of hours service, and information on the out of hours service is consistent across the practice leaflet, website and telephone answer message.

Dr Sunil Mayor

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included two GPs, a practice manager, a practice nurse and an expert by experience.

Specialists who take part in the inspection are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Dr Sunil Mayor

Dr Sunil Mayor also known as Bath Road Surgery is located in the London Borough of Hounslow which provides primary care services to approximately 8,800 patients. This is the only location operated by this provider.

Dr Sunil Mayor is registered to provide the following regulated activities:

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

The patient population groups served by the practice include a cross-section of socio-economic and ethnic groups. Staff said the majority of patients registered with the practice were from an Asian background. A large number of patients are between the ages of 20 and 35 years.

The practice team was made up of; one principal male GP, seven locum GPs three of whom were regular, a part-time practice nurse, a phlebotomist and two healthcare assistants, a practice manager and six reception and administrative staff.

The practice leaflet states that the reception is open from 0800 each weekday, however the practice website states reception opens at 0700 on Wednesdays. Appointments can be made between:

9am - 7:30pm Monday

9am - 6pm Tuesday & Thursday

7am - 12:30pm Wednesday

8am - 5pm Friday.

The practice does not close for lunch and patients can arrange to speak with the GP at 12noon and 3pm each weekday with the exception of a Wednesday when the practice is closed from 12:30pm.

Patients were able to book an appointment and request a repeat prescription online.

Extended hours operated for pre-booked appointments only 6:30pm to 7:30pm Monday and 7am to 8am on Wednesday.

Dr Sunil Mayor does not provide an out-of-hours service. The practice information leaflet informed patients how to contact the out of hours provider. It also provided a number for NHS Direct service which is no longer available. The practice website and telephone answer machine advised patients to contact the NHS 111 service when the practice was closed. They did not refer to the separate out of hours provider mentioned in the practice leaflet.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme and to follow-up on a warning notice we had served follow our last inspection visit on 8 September 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)

We carried out an announced visit on 8 January 2015 and a visit to follow up a previously served Warning Notice on 3 February 2015. During our visits we spoke with three GPs, the practice nurse, the practice manager, the phlebotomist, two healthcare assistants, two administrator and two receptionists. We also spoke with 11 patients and observed how people were being cared for. We talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 33 CQC comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks such as electronic alerts which flagged concerns on patient records and multi-disciplinary meetings.

The practice had learnt from serious incidents / significant events such as the recent issuing of repeat prescriptions without an authorised request. We saw that as a result of an identified breach of their internal repeat prescriptions policy, the practice had changed the way it processed repeat prescriptions. Not all staff were aware of this as one member of staff told us they did not think there had been any recent significant events.

Staff we spoke with said the principal GP or practice manager led on all areas of the practice and would approach either or both if they needed to raise a concern or seek advice.

Learning and improvement from safety incidents

There was some evidence of learning and improvements resulting from safety incidents but not all staff were aware of the significant events we saw recorded. We looked at practice meeting minutes which recorded an incident where the practice manager had prevented confidential information from being disposed of in the general waste rather than being shredded. Although it is acknowledged that this had been appropriately recorded and discussed with those staff in attendance to prevent reoccurrence, there was no evidence that this information had been passed to clinical staff who did not attend these meetings.

We were told that national patient safety alerts were emailed to staff by the practice manager. Staff we spoke with were only able to tell us about one recent patient safety alert which related to Ebola. There was no system in place to determine if staff had actually received and read alerts.

The practice had an accident book which had one minor incident recorded in it.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We were told that the practice took into account people's medical history and living circumstances to identify those at risk. The practice used an electronic system to manage patient records. This system would be used to flag up vulnerable patients (although we were told the practice did not have any who met this criteria at the time of our visits) and those where safeguarding issues had been made identified.

We were told that the practice had a good working relationship with social services and participated in multidisciplinary meetings as needed. Children who did not attend appointments were flagged up and where appropriate social services were informed. The practice had one child on the child protection register. Although the practice did not hold regular formal meetings with the health visitor, staff said they raised concerns as they occurred. We saw evidence where a vulnerable child had been made known to the practice; concerns regarding this child had been followed up and acted on appropriately.

We were told by the practice manager that all staff had completed online training modules regarding safeguarding vulnerable adults and children. Staff we spoke with knew how to recognise signs of abuse and knew how and who to report any suspicions to. However several staff commented that safeguarding was not discussed at practice meetings. We saw adult and child safeguarding e-learning training certificates dated March 2014 for three staff and other staff told us that they had completed training in October and November 2014. We noted a safeguarding vulnerable adult's poster, which included a flowchart showing the reporting process, on display for staff to follow.

The practice had a chaperone policy which most staff were aware of. Staff said that patients were informed of their right to have a chaperone present during intimate examinations when they first registered with the practice. The principal GP told us that all patients were offered a chaperone whenever an intimate examination was to be carried out or offered the option of an alternative appointment with a female GP or nurse. Two patients we spoke with confirmed that the female nurse had been present when they had been given an intimate examination by a male GP. We were told that some staff were trained as chaperones and newer staff were due to have training. One member of staff who had been in post for a number of months told us that they had acted as a chaperone and confirmed that the chaperone procedure had been explained to them. We saw that staff who acted as a chaperone had an appropriate DBS check in place.

Inadequate

Are services safe?

Medicines management

We checked medicines stored in two refrigerators, one for child immunisations and one for travel vaccines. Both refrigerators were lockable and secure. The practice nurse who worked two days a week was responsible for checking the temperature of the refrigerators. Although we saw records of daily checks which were within the acceptable range, the nurse did not know who checked the temperatures in their absence and what action to take if they found the refrigerators to be over the recommended temperature.

We viewed the computer records for child immunisations which evidenced accurate recording of batch numbers. We saw that all immunisations and vaccines were in date and staff were aware of the need to ensure medication was used in chronological order. The practice was listed as a yellow fever centre authorised to administer yellow fever vaccinations and the principal GP held the certificate of training for the practice for this. We were told both the nurse and the principal GP administered these vaccinations. We were told the nurse administered vaccines under Patient Group Directions (PGDs) there were appropriate directions for the nurse to administer vaccines however we were informed that these were drafted and signed by the practice manager which is contrary to legal requirements. We were provided with copies of appropriately signed PGDs post the inspection however these had expired in August 2014.

We were told that no controlled drugs were held on the premises.

We looked at the doctor's bag which was kept securely in a non-public area and saw it contained all relevant equipment and a prescription pad. We were told that the principal GP was the only GP who undertook home visits and the only GP at the practice who had a handwritten prescription pad.

At our last inspection visit on 8 September 2014 we found that the practice's repeat prescriptions process was not robust. As a result of this, a staff member was found to have breached the practice's own policy on the processing of a repeat prescription. Although the practice had carried out an investigation, this had not been robust and appropriate processes had not been followed through. At this inspection we found that the practice had revisited the investigation and had implemented a revised administration process. We saw a number of prescriptions awaiting collection some of which dated back to September 2014. Although the revised administration process was more robust, the practice was still unable to audit trail repeat prescriptions which were older than four weeks as the original patient request was destroyed after four weeks regardless of whether the prescription had been collected or not. This meant that the practice would not be able to evidence who had actually requested the repeat prescription if the request was more than 4 weeks old.

New supplies of blank computer printing prescription forms were kept in a locked cabinet in the reception area. The practice did not however have an adequate system for recording which prescription serial numbers were issued to which GP.

Cleanliness and infection control

We observed the premises to be clean, tidy and well organised. We viewed the cleaning schedule and records which detailed daily, weekly and monthly tasks, and the cleaning contract.

We saw invoices for the monthly collection of clinical waste and a Legionella certificate for the practice which was in date (Legionella is a bacteria which causes serious illness). We also saw appropriate containers for used sharps. We noted however noted that one of these sharps bins was on the floor.

The kit to deal with spills of bodily fluids (which could lead to infection) was kept in the cleaner's cupboard and staff we asked knew where it was located.

The practice had a policy for needle stick injury and an infection control policy and supporting procedures. These enabled staff to plan and implement measures to control infection, such as the use of personal protective equipment. We saw that disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

The practice had an appointed lead for infection prevention and control however, most staff were unaware who this person was. We spoke to the appointed lead about an infection prevention and control audit but they

were unable to tell us if one had been undertaken in the last 12 months. There was evidence to demonstrate that the infection prevention and control lead had received appropriate training.

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 most treatment rooms, however we noted that there was no sink in the treatment room which we were told was used for the testing of HIV.

Patients we asked all confirmed that the nursing and medical staff always wash their hands before examinations and wear protective clothing if necessary. We observed one receptionist using hand sanitising gel when they entered the patient waiting area.

We noted that the practice nurse did not have any sterile gloves which were within their use by date. We saw four packs in total, two packs had expired in 2011 and two in 2012.

We also noted that some single use equipment had been stored unpackaged in a treatment room drawer. Although staff using this room said they did not use these items they were unable to say why they were there or if anyone else used them.

Equipment

Staff we spoke with told us they had appropriate equipment to enable them to carry out diagnostic examinations, assessments and treatments.

We were told that the practice had twenty four hour blood pressure monitoring equipment and spirometry equipment (used to measure lung function).

We saw that a portable appliance testing (PAT) certificate was present and in date for all equipment which required it and also calibration certificates were present as appropriate.

Certificates relating to the checking and servicing of equipment such as the annual service for the supply of gas to the building and the servicing of fire safety equipment were all available for inspection and up to date. We noted that the paperwork relating to the staff lift dated 2014 stated 'non examination'. Although patients did not have access to the lift, the practice should have ensured all equipment available for use by staff was appropriately checked and safe for use.

Staffing and recruitment

The practice clinical staff comprised of the principal GP, who took the lead for all aspects of clinical practice and was the only permanent GP at the practice. Other clinical staff comprised of a part time practice nurse, who worked two days a week, two healthcare assistants and a phlebotomist. We were told that other GPs at the practice were all locums and the practice was finding it difficult to recruit GPs on a permanent basis.

Appropriate recruitment policies and procedures were in place to support good practice, however we found these had not always been followed. We looked at four non-clinical staff recruitment files and saw a Disclosure and Barring Service (DBS) check had been obtained for all four. None of the four files we looked at however contained all other appropriate recruitment documents such as, curriculum vitae (CV), photographic proof of identity, employment history, right to work and reference checks. We discussed this with the practice manager who was responsible for staff recruitment. The practice manager told us it was extremely difficult to recruit staff and confirmed that they had not always followed the practice recruitment procedure. One of the files we looked at contained a CV where gaps in employment history had no explanation or evidence that this had been explored. We also found that references were not taken up consistently. In addition the practice manager could not demonstrate that the recruitment process operated within equal opportunities requirements, for example there not was evidence of recruitment short listing or selection criteria or a record of interview questions and / or answers.

One member of staff we spoke with told us that they were interviewed on a Friday by the practice manager and started work the following Monday. This member of staff told us that they had had no induction and felt unsupported in their role. Some staff said that they were not given sufficient information to carry out their tasks and did not feel supported, whilst others said they did feel supported and felt confident to raise concerns.

Are services safe?

Staff told us that they had monthly appraisals / reviews of their work during their probation period and an annual appraisal once they had passed their probation. We did not see any written evidence of these monthly appraisals on the four staff files we examined.

Monitoring safety and responding to risk

The principal GP told us that the practice had a higher than average number of patients attending accident and emergency departments (A&E). We were told that the principal GP contacted patients by telephone who had recurrent attendance at A&E. We also saw there was a link on the practice website to 'Choose better not A&E' which gave patients alternatives to attending accident and emergency departments.

We were told that the practice had good links with the blood testing laboratory, who were able to contact the principal GP directly on their mobile phone if out of hours and results raised urgent concerns. The principal GP told us that they took responsibility for all telephone consultations and dealt with all test results for continuity. We reviewed the electronic folder containing letters relating to patient results that had been scanned into your system by the health care assistants. We saw more than 500 that had not been opened, the date of the first of these being October 2014. There were a total of 1924 waiting to be seen.

The principal GP said that locum GPs were shown the electronic computer system, which flagged up prescribing guidelines which supported the GPs with their prescribing practices.

We were told by a locum GP that patients on long term medicine were reviewed annually and if a patient did not attend for review any repeat prescription requests were limited to a month's supply and then a week until the review had taken place. We were given an example of a patient who was called in to see a locum GP requesting a particular medicine to be prescribed. The locum GP said they had discussed this with the principal GP who was able to advise. Patients we spoke with confirmed the GP regularly reviewed their medicine

The practice computer system automatically highlighted patients who might be at risk of dementia.

The practice had access to an electronic single point referral service within Hounslow which GPs told us was very helpful and easy to use. The practice electronic system flagged up all patients identified as at risk of deteriorating health who had an AUA (avoiding unplanned admissions) care plan. We were told that these patients were always invited into the practice to meet with the GP following any discharge from hospital.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff except two newly appointed administrative staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Records confirmed the defibrillator had been checked regularly. It was noted that the main oxygen cylinder was empty however the practice did have access to a portable cylinder. Not all staff knew the location of this equipment.

Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia, and were available in a secure area of the practice however the practice did not have 1:10000 adrenaline solution and not all staff knew where the emergency medicines were stored.

One staff member we spoke to was able to relate an incident of a patient becoming unwell which they had dealt with appropriately.

A business continuity plan, dated December 2014, was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and actions recorded to reduce and manage the risk. Risks identified included the outbreak of an infectious disease, power failure, flooding and fire. The document also contained some relevant contact details for staff to refer to such as secondary healthcare services.

We viewed the practice's procedure in the event of fire and saw records of regular testing of the alarm. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training. We were told that fire drills were held regularly and that they included a full evacuation of the building every three months. The fire log evidenced weekly checks but there was no record of the dates of the full evacuations.

Inadequate

Are services safe?

We saw posters on the walls in staff areas detailing actions in the event of emergencies and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs 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. We saw two ad hoc minutes of practice clinical meetings for June and August 2014 where NICE guidelines were discussed. However we noted the attendance of locum GPs at these meetings was very low. The principal GP told us this was due to locum commitments elsewhere. There was no system in place to ensure decisions made at these meetings were communicated to the locum GPs.

We were told by the practice nurse that they kept up to date with good practice and current guidance from NICE through their on-going employment at a local hospital.

The principal GP said they were the clinical lead in all areas except infection control and prevention and, as they were at the practice every day, could provide locum GPs with advice and support as and when needed.

The principal GP showed us data from the local Clinical Commissioning Group (CCG) for the practice's performance for antibiotic prescribing. This showed the practice had achieved 86% of its total target which was comparable to similar practices.

The practice had two healthcare assistants who undertook new patient health checks and opportunistic health monitoring checks for those patients referred by the GPs for weight and blood pressure monitoring. Some staff expressed concerns that they were being asked to undertake monitoring tasks for which they had not been trained.

The practice referred patients to secondary care services, and several of the patients we spoke with confirmed this and stated that they had received copies of the referral letters. We saw the practice had undertaken an audit to look specifically at their performance relating to the two week wait (a referral scheme to ensure that patients with urgent conditions are seen by a specialist within two weeks of a GP referral). This showed that 82% of referred patients had been seen within this timescale. The audit concluded this was encouraging and made no recommendations for action to improve this rate so that it achieved the 100% target.

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 according to need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. We were told the information staff collected was then collated by the principal GP and practice manager to support the practice to make improvements. However, there was limited evidence available to support this.

The practice was unable to show us any completed clinical audits. We were shown three audits which had been undertaken; for usage of non steroidal anti-inflammatory drugs, for the usage of statins in type 2 diabetes and cancer two week referrals. There were recommendations made in response to two of the audits (NSAID usage and statin usage in diabetic patients) however there was no evidence of action taken. However, as these audits had not been repeated the practice was unable to demonstrate how they had used these to improve patient care.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. We were told that the practice used the information collected for the quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. We saw that the practice had met 83% of its annual target for cervical smear testing. However the practice was below the expected CCG target for the identification of patients with chronic obstructive pulmonary disease (lung disease) and also for the percentage of patients with diabetes whose blood glucose level had been 64mmol or less in the preceding year (the higher the level the more likelihood of poor control of

blood glucose levels). We noted that locum GPs were not routinely involved in clinical meetings and those we spoke with did not know if the practice was meeting its QOF targets.

There was a protocol for repeat prescribing. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and checked that all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines, and any patients discharged from hospital who had a care plan were also flagged up so that care could be followed-up.

We were told that the practice had a good working relationship with the local hospice and regular contact with a Macmillan nurse. The practice held a palliative care register. However when we reviewed the notes for the one patient who was on this register, it was unclear whether their inclusion on it was appropriate as they were not in receipt of end of life care. We discussed this with the principal GP who agreed that this patient should not have been on this register.

We were told that the principal GP was the named GP for all vulnerable patients including those over the age of 75.

The practice had signed up to the dementia DES (directed enhanced service) to increase identification of those patients with dementia care needs. The principal GP was the named GP for patients with dementia who lived in a local care home.

The practice participated in a local enhanced service (LES) for the monitoring and reduction of attendance at accident and emergency departments.

Effective staffing

Practice staff comprised of medical, nursing, managerial and administrative staff. There was one permanent male GP and a varying number of male and female locum GPs. The principal GP told us that they recognised the need to employ more permanent GPs and said they were in the process of doing so. Patients told us that regular changes in GPs affected their continuity of care.

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. We were told that during busy periods the practice did not have pre-booked appointments and that the practice always ensured there was sufficient GP cover.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Locum GPs told us that they received an induction on their first day of work from the practice manager who took them through the operation of the practice's systems and procedures. We spoke to three locum GPs who felt that the practice was well run and they felt supported in their roles.

The principal GP took responsibility for all telephone consultations and dealt with all test results for continuity, however we found on the day of our inspection visit on 8 January 2015 that not all patient letters relating to test results had been dealt with in a timely manner. We looked at the electronic records and found 1924 awaiting action with dates going back to October 2014

We were told all staff undertook annual appraisals that identified learning needs from which action plans were documented, however most staff had been in post for less than 12 months and some had not yet had an appraisal.

We reviewed non-clinical staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support and safeguarding. Interviews with staff confirmed that training was available but some staff said that online training had to be undertaken in their own time. Some staff told us that the practice manager offered support and training; however others were unsure of their roles and were not familiar with the practices policies and procedures.

The practice nurse worked two days a week and was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example the administration of vaccines and immunisations and cervical cytology.

Working with colleagues and other services

The practice was part of the Hounslow Clinical Commissioning Group (CCG) and attended regular monthly

meetings. The principal GP, practice manager and/or practice nurse also attended mandatory HEAT (Hounslow education and training) sessions organised by the CCG every three months. Over the past two years these training sessions had covered areas such as care pathways, safeguarding and new clinical guidelines.

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 111 service both electronically and by post. (NHS 111 service is a telephone based service where patients are assessed, given advice and directed straightaway to a local service that can help them best. This could be an out-of-hours doctor, walk-in centre or urgent care centre, community nurse, emergency dentist or late opening chemist). The practice had a policy outlining the responsibilities of all relevant staff in reading and acting on any issues arising from communications with other care providers on the day they were received. It was the responsibility of the principal GP to read and action all letters and test results.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients. For example, those with end of life care needs or children on the at risk register. Meeting minutes evidenced that although district nurses, midwives, health visitors and palliative care nurses were invited, the health visitor and palliative care nurse had not attended any of the meetings throughout 2014. Meeting minutes although brief evidenced that information was shared with those who attended but it was unclear how care and treatment was planned or improved by these meetings or how information was shared with those that were unable to attend.

We were told that the principal GP and the practice nurse held joint anti-natal and post-natal clinics. The practice also worked with midwives under shared care arrangements.

We were told that the practice had a good relationship with a local hospice and had quarterly multidisciplinary telephone conference meetings to plan and coordinate integrated end of life care.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Those patients seen by the out of hour's service who did not contact the practice themselves were contacted by the practice and an appointment arranged. We were told that one third of morning appointments were for emergencies.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. 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. We were told that all letters received at the practice were looked at and clinically coded by the practice manager. Those that required no further action were scanned into the electronic system and those requiring action were passed to the principal GP.

The practice used an electronic computer system to access a single point referral service which operated within their clinical commissioning group. Staff said this worked well and was easy to use.

The practice website offered patients information on the electronic summary care record, including how to opt out of they wished. (Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency).

Consent to care and treatment

We saw documented patient consent to blood tests and cervical smear tests. We also saw evidence that where agreed a patient had been texted their test results. Most patients we spoke with confirmed that they had been asked their consent before an examination, although some patients were not sure if they had ever been formally asked.

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All 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 some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help

staff. For example, with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in. We were told that the practice had 16 patients with a learning disability registered with the practice. We were told all had a care plan but the principal GP was unable to tell us how many of these had received an annual health check in the year 2014/15. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test (used to help a clinician assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Clinical staff told us that a patient's verbal consent was sought and recorded in the electronic patient notes for vaccinations, immunisations, intimate examinations and blood tests.

We saw evidence on patient records that medicines were reviewed and appropriate notes recorded.

Health promotion and prevention

The practice carried out opportunistic NHS health checks when patients aged between 40 and 74 attended appointments. The healthcare assistant told us that they checked a patient's blood pressure and weight when they were referred to them by the GP. The principal GP told us that patients over the age of 75 had all been seen in the last six to twelve months for a health check. We were told that new patients received a health check as part of their initial registration.

Eighty nine percent of patients had been offered smoking cessation advice which the healthcare assistant had been trained in, and all smokers over the age of forty were invited in for a test to detect lung conditions (spirometry). However the practice was not working towards a target for smoking cessation and did not monitor how many patients had stopped smoking.

We were told ante-natal and post-natal checks were carried out by the principal GP and practice nurse. The principal GP said that they undertook the first four ante-natal shared care checks with hospital based midwives and worked with health visitors in post-natal patient care.

The practice had regular monthly meetings with the Clinical commissioning Group (CCG) where they discussed local patient health. We were told that the practice used this information to help focus health promotion activity. The principal GP said they had tried to increase patient accessibility to the practice through the introduction of Saturday clinics which focused specifically on increasing the take up of cervical screening. In addition it was hoped that the extended hours provided by practices within the locality would help reduce the number of unplanned Accident and Emergency admissions.

The practice's performance for cervical screening uptake was 84%, which was 2% above the expected figure. We were told that text reminders were sent to patients due cervical smears. The practice nurse was responsible for carrying out cervical screening tests, though they did not know what their target was or how well they were doing.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was comparable with other practices within the CCG. It exceeded the CCG average for all immunisations for 5 year olds, for example for the MMR dose 2 vaccine where it achieved 88.8% compared to the CCG average of 76.5%. If fell below the CCG average for Meningitis C vaccination in babies up to 12 months, attaining 75% compared to the CCG average of 78.9%; but exceeded the average for the PCV (pneumococcal) vaccine accomplishing 93.6% compared to the CCG average of 91.8%.

We were told that the practice nurse had a special interest in the management of diabetes. The principal GP and practice nurse were responsible for the care of the 632 identified patients with diabetes. Data showed that 96% of patients with diabetes had received a foot examination in the last 12 months and 93% of patients with diabetes had received a micro-albuminuria test (a test to check for kidney damage) which was comparable with other practices within the CCG. However data indicated a below

Inadequate

Are services effective?

(for example, treatment is effective)

average percentage of patients with diabetes whose blood glucose level had been 64mmol or less in the preceding year (the higher the level the more likelihood of poor control of blood glucose levels).

The practice held a register of patients with dementia and had signed up to a Directed Enhanced Service (DES) to increase identification of patients with this condition. We were told that the practice's computer system flagged up to GPs those patients who were at risk of dementia however there was no available data to indicate if this system was effective.

Although the practice had identified patients with poor mental health most of these patients had not received regular physical checks. We noted that there were insufficient arrangements for the management of patients with mental health, depression and diabetes, in addition there was a high rate of patients attending accident and emergency (A&E) services. Although the principal GP had recognised the need to address the high A&E attendance there were no records to support how they were doing this.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The principal GP said that they felt they knew the elderly patients with chronic conditions registered with the practice well and they demonstrated this in their conversations with us. However the practice could not demonstrate they had sufficient knowledge of other vulnerable population groups as patients with mental illness were not routinely offered an annual health check; the number of patients with a learning disability who had had an annual check up was unknown, and whilst vulnerable patients were flagged up on the practice's computer system we were told they had care plans in place, the principal GP stated that none of the patients met the criteria for vulnerable.

Most patients we spoke to had been with the practice for ten to twenty years and stated that they were always treated with dignity and respect, and that all staff were respectful and compassionate. Most patients stated that they were not rushed, however, we were told by one patient that there was not always sufficient time to investigate all symptoms as the practice had a policy of 'one complaint one appointment'.

Several patients stated that the GPs explained all conditions and treatments in a way that was clear and understandable.

Although the practice did not actively promote its services with homeless organisations, we were told that there were four or five homeless people registered with the practice. We were told that the practice would let homeless people use the practice address in order to access services and also book hospital appointments for them using 'choose and book' (a computerised system for patients to book their own hospital appointments). The principal GP cited one occasion when he had attempted to mediate between a homeless couple whose relationship had broken down.

We received 33 completed Care Quality Commission (CQC) patient comment cards. Patients said they felt the practice offered an efficient, helpful and caring service. They said staff were polite and very helpful. We also spoke with 11 patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some patients said they did not always get to see the GP of their choice and felt weekend opening would be helpful. Some patients did not know how to contact the out of hour's service and some felt there was limited information available regarding the specialist clinics available at the practice.

The National Patient Survey 2015 indicated that 75% of respondents found it easy to get through to this surgery by phone, the CCG average being 72%; and 82% said the last GP they saw or spoke to was good at giving them enough time (CCG average 82%). However only 47% of respondents with a preferred GP usually get to see or speak to that GP (CCG average: 57%); 72% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81%; and 51% usually waited 15 minutes or less after their appointment time to be seen, compared to the CCG average of 59%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 / treatment room doors were closed during consultations, however when we viewed the premises we noted that conversations could be heard through the adjoining wall between the phlebotomy room and the nurses room which could lead to a breach of confidentiality.

We saw that reception staff were careful to maintain confidentiality when speaking to patients.

The practice had a zero tolerance for abusive behaviour which was recorded on the practice leaflet and on the practice website.

Care planning and involvement in decisions about care and treatment

We were told by the principal GP that all patients at risk of unplanned hospital admissions were highlighted on the computer system and invited to the practice where an avoiding unplanned admissions (AUA) care plan was drawn up. Care plans involved the patient and where appropriate a relative or carer. We viewed two of these care plans and found these had been completed satisfactorily.

Requires improvement

Are services caring?

We were told that patients were contacted by the GP, usually by telephone following a hospital discharge. One patient we spoke with confirmed this and another stated that they always received a copy of letters sent between the GP and hospital.

We saw evidence on patient records that patients were sent text messages for test results, appointment reminders and other relevant information where possible. Patients we spoke with confirmed that the principal GP telephoned them if there were any problems with test results, however we found a high number of test results that had not been actioned.

We were told that consent was sought from patients by the GPs, practice nurse and healthcare assistants for intimate examinations and some treatments, such as childhood immunisations and injections given to patients in their joints. We saw evidence that consent was recorded on the patient electronic computer record.

The National Patient Survey 2014 indicated that 72% of respondents said the last nurse they saw or spoke to was good at involving them in decisions about their care (national average: 85%) and 65% said the GP was good at involving them in their care, which was below the national average of 81%.

The results from the practice's patient participation group (PPG) survey for January 2014 showed a 89.5% satisfaction score compared to 91.5% nationally. The practice had responded to this by clarifying with patients the practice policy for 'one patient one symptom' for each ten minute appointment.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. The practice website information could be accessed in a variety of languages, but we noted that the printed information leaflets available at the practice were only available in English. We were advised by the practice that information leaflets could be requested in languages other than English.

Patient/carer support to cope emotionally with care and treatment

We were told there were just three registered housebound patients all of whom received regular home visits from the principal GP. We were also told that the practice strived to support carers by identifying the families of housebound patients and being more flexible with appointments and prescription services; and that the practice regularly contacted patients relatives who acted as their carer. We received negative feedback through our contact with patients, one of whom commented that the practice did not recognise the carers role.

The patients we spoke to on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and they were supportive and understanding at times of bereavement. One patient we spoke with said they had been referred to counselling which they had found helpful.

We were told that the principal GP endeavoured to act quickly to requests for support from people who were reaching the end of their life. They said they would keep in regular contact with recently bereaved family members, and carers of those who had died. We were told of a recent unexpected death of a patient where the principal GP dealt with the coroner and visited the family on the same day. Staff told us that if families had suffered a bereavement their usual GP contacted them. This call was either followed by a patient consultation at a convenient time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The principal GP said they had a good working relationship with the Macmillan nurses at the local hospice and took part in quarterly multidisciplinary teleconference meetings.

We were told that staff had received training in understanding domestic violence.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged regularly with the Clinical Commissioning Group (CCG) and other practices within their locality to discuss local patient needs and service improvements. For example the practice was part of an eight practice locality group which had taken part in an additional weekend opening scheme where they provided a GP service to all patients within their locality one Saturday in eight.

Although the principal GP told us that they knew their patient population and was responsive to patient needs, we found the practice did not have effective systems in place to respond to the needs of the various population groups. For example, we were told that 16 patients with learning difficulties were registered with the practice and attended with a relative or carer for appointments. However, the principal GP did not know how many of these patients had had an annual health check. In addition, although the practice had identified patients with poor mental health, most of these patients had not received regular physical checks.

We were told that the practice held ad hoc Saturday walk in sessions for flu vaccinations. Staff said patients were sent text messages inviting them to these.

The practice manager said the practice had implemented changes in the way it recorded a patient's hospital attendance following a complaint. This had highlighted a gap in the practice procedure which was reviewed and changed to reflect the improved practice.

The practice had also implemented improvements to the telephone system in response to patient feedback from the patient participation group (PPG). Patients had raised concerns that there were often long delays or the telephone was engaged when they called. The practice had upgraded their telephone system by adding three extra telephone lines in an effort to address this.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, such as extended hours for working age patients which made up the majority of patients registered with the practice.

The principal GP stated that there were no patients registered with the practice which fitted the description of 'vulnerable' patient. This was despite the practice having 16 patients registered with the practice with a learning disability, one child on the at risk register and a small number of homeless patients.

Staff said those patients with "no fixed abode" were able to use the practice's address to access secondary care services.

We were told that the practice had a large number of patients who did not speak English as a first language. The practice had access to translation and interpreter services, and staff were able to speak some other languages, but its practice leaflet and patient forms were only available in English. One patient we spoke to said that they would like to see more of the printed information available in Punjabi. The practice advised us that printed information leaflets could be requested in languages other than English.

We were told that some patients request medicines which are available over the counter to be prescribed and the practice was trying to educate patients to make more use of the pharmacy for minor ailments.

The practice was situated on the ground floor of the building where all services for patients were provided.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The waiting room had a self-check in screen which promotes efficiency and confidentiality.

The practice reception was open from 7.00am Wednesday and 8.00am on other weekdays. Appointments were available to patients between 9.00am to 7:30pm Monday, 9.00am to 6.00pm Tuesday and Thursday, 7.00am to 12:30pm Wednesday and 8.00am to 5.00pm Friday. Out of hours was covered by an external specific out of hours provider. The number for this provider was given in the practice leaflet, however it was not provided on the practice website or in the telephone answer message, both of which directed patients to the NHS 111 non clinical advisory service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Information on opening times and how book an appointment was available in the practice leaflet, on the practice website and via a recorded telephone answer message. We noted however, that these were inconsistent in the information they gave. In addition, the practice leaflet told patients to call 999 in an emergency or the specific external out of hours provider. It also gave a number for the NHS Direct service which is now non operational. The practice website told patients to call 020 8577 9035 for emergencies or urgent GP medical care and the recorded telephone answer message told patients to contact the NHS 111 service for urgent medical problems outside of surgery hours.

Staff described the appointments system. We were told that appointments could be booked up to four weeks in advance, requests for urgent appointments could usually be accommodated on the same day and patients could request a specific GP however this choice was limited given the practice used 7 locum GPs.

Patients confirmed that they could see a GP on the same day if they needed to and felt access to urgent appointments was good. However, they were not always able to see a GP of their choice. Most patients we spoke with were happy with the practice opening times, but some were unaware of the out of hour's service or the specific clinics which the practice offered. Patients who contacted the reception for a Username and Password could then book appointments online, however this facility was not mentioned in the practice leaflet and the practice's website address was not provided.

Appointments were available outside of school hours for families, children and young people. Staff told us that home visits were available where needed, in particular for older people with a view to minimising hospital admissions. We were told that the practice operated a '1 appointment = 1 patient + 1 problem' system, though longer appointments were available where needed, for example for patients with learning difficulties or those with long term conditions. Where appropriate, online or telephone consultations were offered every week day between 12 noon and 3pm to enable people to manage appointments around work and an online booking system was available. We were told that text message reminders were sent to patients for appointments and test results.

The principal GP told us that homeless people and travellers were occasionally seen as temporary patients. There were three housebound patients registered with the practice, all of whom we were told received regular visits from the principal GP for review.

Listening and learning from concerns and complaints

The practice had an appropriate complaint policy / procedure. Members of staff we spoke with stated they would refer complaints to the practice manager and were aware of the complaints procedure. Although the practice had a complaint book in place not all staff we spoke with were aware of it. The practice also had a suggestion box in the reception area, which we were told had been in place since September 2014.

We received 33 CQC patient comment cards, all of which had positive comments about the practice. We spoke with 11 patients on the first day of our visit, some of whom were unaware of the complaints procedure or how to raise a formal complaint. Five patients we spoke with said they were happy with the service provided and some said they had come into the practice especially to meet with us to say how good the practice was. One patient said they felt a family member had not been treated effectively at the practice and had symptoms ignored and another felt that the practice did not recognise their role as a carer. Another patient said a locum GP had not paid attention to patient notes and tried to prescribe medicine for a family member who was allergic to it. And another felt complaints never went any further than the practice manager.

The principal GP told us that the majority of complaints they received were verbal and related to the availability of appointments and patients not being able to see the GP of their choice. The practice did not have a system in place for recording verbal complaints. The principal GP told us that patients who made verbal complaints were advised to use the formal complaints procedure.

We were told that patients had complained about the lack of continuity among the GPs at the practice. This was confirmed in discussions with patients and in the PPG meeting minutes. The practice had acknowledged this and we were told by the principal GP that they were actively recruiting for permanent GPs from amongst the locum GPs they were using. Locum GPs we spoke with however were not aware of this.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Practice meetings minutes evidenced that complaints were shared with staff and lessons learnt. For example we saw a complaint concerning a magnetic resonance imaging (MRI) report which had been discussed in November 2014. The reason for the complaint had been explored, and the learning from this had been documented in the minutes. We noted however that there was no written procedure in place to support staff to deal with patient queries relating to test results.

The practice told us that complaints were analysed for trends. We were advised that the only consistent trend identified in recent years related to appointments running late and this had been resolved.

Not all staff we spoke with felt they were listened to or that they could raise concerns about working practices if they needed to.

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

The practice had a clear vision to deliver high quality care and promote good outcomes for patients which were set out in their statement of purpose which we viewed. We also viewed the practice's business development plan for 2014 - 2018 which contained future plans such as moving to bigger premises, and improving the practice website. We noted however the document did not address patient concerns regarding continuity of care or make reference to the recruitment of any permanent GPs.

Governance arrangements

There was a limited leadership structure for the practice. We were told that the principal GP was the lead in most clinical areas and attended the practice every weekday covering up to nine clinical sessions. All other clinical sessions were undertaken by locum GPs. We were told by the principal GP that the practice was trying to recruit permanent GPs. We spoke with a number of staff some of whom were not clear about their own roles and responsibilities. They did not feel valued, and were not comfortable raising concerns.

The practice had a number of policies and procedures in place to govern activity and these were available to all staff on the desktop on any computer within the practice. Not all staff were familiar with key policies and procedures however, such as those relating to whistleblowing or induction. Clinical discussions regarding QOF data were ad hoc and there was no formal system in place to support the learning and development of the practice. The practice did not have an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken

The principal GP was responsible for patient test results. We looked at the computer system for incoming patient test results and found the monitoring and actioning of test results was inadequate.

We saw evidence of regular practice meetings where relevant issues were discussed such as the chasing of referrals, complaints and quality outcome framework (QOF). Non-clinical meetings were attended by non-clinical staff and the healthcare assistants. We were advised the practice manager verbally updated staff who did not attend. We were shown the minutes of meetings where the practice nurse had met with the principal GP in November and December 2014 and two in June and August 2014 where the principal GP had met with two other GPs.

The practice had a business continuity plan which gave instructions on what action to take to maintain a service if the day to day running of the practice was disrupted, for example by fire or a power cut. This was thorough and covered all likely events.

Leadership, openness and transparency

Some members of staff told us that team meetings were held every two to three months and that short informal meetings took place at the end of each day to discuss issues that may have arisen. The practice nurse told us that they had ad hoc discussions with the principal GP as required.

We spoke to two locum GPs who stated that they were not involved in practice meetings due to work commitments. The principal GP confirmed that clinical meetings had not been held regularly.

The practice manager told us that information was shared among the staff group via email, however there was no system in place to ensure the information was received.

Some members of staff we spoke to told us did not feel supported in their work and were being asked to do tasks they were not equipped to do.

Seeking and acting on feedback from patients, public and staff

The practice had a patient participation group (PPG), but we were told that attendance was poor and the forming of a patient participation group for the whole borough was being looked as this had been suggested by the local clinical commissioning group (CCG). The practice website contained reports from the patient participation group and documents examples of the practice acting on suggestions from the PPG. For example, when the difficulty of getting through to the practice by phone was raised, the practice updated their phone system to include more lines; concerns over continuity of care due to an unfilled GP post were also discussed and an agreement was reached to engage locums on longer term contracts.

None of the patients we spoke with could remember being asked what they thought of the service by practice staff or

Are services well-led?

Inadequate

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

completing any questionnaires, though there was a 'Friends and Family' questionnaire which could be completed on the practice website. The 'Friends and Family' test asks patients if they would recommend the practice to friends and family.

The practice had a whistleblowing policy, though some staff were unaware of this.

Management lead through learning and improvement

With the exception of the principal GP, all GPs working at the practice at the time of our inspection visit were locums. We were told by one locum GP that they had ad hoc clinical discussions with the principal GP and that they had contributed to their annual appraisal and revalidation. However, there was limited evidence to demonstrate how the principal GP monitored the work of these locums.

Other clinical staff comprised of a part time practice nurse, a phlebotomist and two healthcare assistants. There was limited evidence to demonstrate that these clinical staff were supported to maintain their clinical professional development through training and mentoring. Staff said they were not aware of any planned reviews, role development or planned progression timescales.

We were told that staff had annual appraisals which were planned two weeks in advance, with staff being sent a form to complete which raised points for discussion. Most staff, however, had only recently been employed. Staff who had been in post for 12 months or more confirmed that their received an annual appraisal which covered training needs.

The practice had completed a review of significant events and other incidents which were shared with staff at practice meetings. Not all staff, however, attended practice meetings and although we were told the practice manager passed on relevant information to clinical staff this was not recorded.

This practice had previously been served with a Warning Notice with regard its failure to adequately assess and deal with risks to patients, specifically with regard to repeat prescriptions. At the inspection on 3 February we found that the practice had reviewed and updated their repeat prescription policy and had streamlined the system so only senior staff could prepare repeat prescriptions and only the principal GP could sign them. They had also informed other professional bodies of the concerns CQC had found and the action they had taken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not protected people against the risk of untrained staff. This was a breach of regulation 23 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure staff receive appropriate support, appraisal and training as is necessary to enable them to carry out the duties they are employed to perform and where such persons are health care professionals that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role. Regulation 18 (2)(a)(c)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of receiving unsafe care and treatment. This was a breach of regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure risks to the health and safety of service users receiving care or treatment are assessed and do all that is reasonably practical to mitigate such risks and ensure that persons providing care or treatment have the competence and skills to do so safely; ensure the proper and safe management of medicines; ensure equipment and medicines are in sufficient quantities to ensure the safety of service users;

Requirement notices

assess, detect, prevent and control the spread of infections; ensure test results are actioned in a timely manner and all correspondence relating to patient care is reviewed by a GP

Regulation 12 (1) (2)(a)(b)(c)(f)(g)(h)(i)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not established effective systems or processes to ensure good governance. This was a breach of regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must establish and operate effectively systems or processes to enable them to assess, monitor and improve the quality and safety of the services. Identify and mitigate risks relating to the health, safety and welfare of service users. Regulation 17 (1) (2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected people against the risk of unsafe employment of staff. This was a breach of regulation 21 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure safe recruitment practices are established and implemented. Regulation 19 (1)(a)(b) (2) (3)(a)(b)