

North End Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at North End Medical Centre on 5 April 2016. Overall the practice is rated as Good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw some areas of outstanding practice including:

- The practice also took part in a programme of Community Health workshops on diabetes, in partnership with a local voluntary agency. We saw these workshops included cooking demonstrations, sample recipes, medical and practical advice and a free diabetic-friendly lunch was also served. The workshops were delivered on a monthly basis and attendance ranged from 50 – 100 at each workshop. Performance for diabetes related indicators was 100% which was 17% above the CCG and 11% above the national average.

Summary of findings

The areas where the provider should make improvement are:

- The practice should review, with an aim to reducing their level of exception reporting in relation to Quality Outcome Framework (QOF).

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice had developed clinical protocols so that the links to NICE and other bodies were embedded in clinical practice.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- The practice met with other local providers to share best practice.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data showed that patients rated the practice higher than others for some aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, local referral pathways for diabetes patients.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Good



Are services well-led?

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The Contracts and performance manager was

Outstanding



Summary of findings

responsible for implementing and monitoring appropriate reporting systems to measure their QOF performance. The QOF data for this practice showed it was performing above national standards.

- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. The practice took part in local pilot schemes to improve outcomes for patients in the area. For example, the practice worked in partnership with a local charity and had appointed a social prescriber to provide non-medical support to patients.
- The practice initiated and hosted weekly lunch time teaching events delivered by consultants which was open to other local practices and all the clinical staff at the practice including the nurses.
- The practice had received an award for their performance in providing NHS health checks to their eligible population. They had 29% achievement against a CCG area average of 20%.
- The practice gathered feedback from patients using new technology, and it had a very engaged patient participation group. The PPG had organised and helped facilitate a 'food bank' for vulnerable patients.

Summary of findings

The six population groups and what we found

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

Older people

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

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. Patients over 75 years had a named GP to co-ordinate their care. They had identified that 7% of their older patients were at risk hospitalisation and all had care plans in place. Double appointments were available for these patients when required.
- Patients were referred to the older person's rapid access clinic and the practice used the virtual ward to prevent unnecessary hospital admissions. Patients in the group were also referred to their pilot social prescribing service for non-medical care needs.
- The practice utilised other support services, such as referring patients to a befriending service run by a local charity, the local Red Cross Services and Healthier Homes. Healthier Homes is a Public Health funded project aimed at reducing GP appointments and Hospital Admissions. It focuses on the health effects of fuel poverty and hazards in the home.

Good



People with long term conditions

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

- The practice had clinical leads for a variety of long term conditions including diabetes and chronic obstructive pulmonary disease (COPD). We saw all clinical members had completed further training in their areas of responsibility and acted as a source of information for other staff. For example, the diabetes lead had completed the 'merit course' (Meeting Educational Requirements, Improving Treatment) which is a flexible modular education programme that helps healthcare professionals to update and deepen their knowledge of diabetes treatment and care so they can better help their patients.
- The practice provided weekly dedicated diabetic clinics run by two GPs and a practice nurse who had also completed

Outstanding



Summary of findings

specialist training. They were able to initiate insulin and other injectable therapies such as GLP-1 (long acting glucagon) which meant patients did not need to go to community clinics or to secondary care.

- The practice also took part in a programme of Community Health workshops on diabetes, in partnership with a local voluntary agency. We saw these workshops included cooking demonstrations, sample recipes, medical and practical advice and a free diabetic-friendly lunch was also served. The workshops were delivered on a monthly basis and attendance ranged from 50 – 100 at each workshop.
- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses to discuss patients and their family's care and support needs.
- The practice provided dedicated COPD and asthma clinics run by their trained nurse who performed spirometry and peak flow tests. These clinics were overseen by dedicated GPs (one each for COPD/asthma) and their advanced nurse practitioner. Patients were given self-management plans including 'rescue pack' antibiotics and oral steroids.
- Services such as spirometry, phlebotomy, ambulatory blood pressure monitoring (ABPM) and anticoagulation management service were carried out at the practice.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, they had a named administrative staff member who monitored paediatric non-attenders to hospital out-patient and community services. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%.

Good



Summary of findings

- The practice triaged all requests for appointments on the day for children when their parent requested the child be seen for urgent medical matters, thus were able to offer appointments at mutually convenient times, for example after school, when appropriate.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. There was GP telephone triage for all requests for same day appointments, which enabled telephone and email consultations where appropriate.
- The practice offered working age patients access to extended appointments six times a week which included weekend appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Pathology results were also sent by SMS texts when requested.

Good



People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Pop up alerts were placed on all computer notes to alert all members of staff of vulnerable patients.
- Learning Disability patients were given care plans that met their needs. Patients with learning disabilities were invited annually for a specific review with their named GP, often on a Saturday when the practice was quieter. We saw 14 out of 17 reviews had been carried out in the last 12 months.
- The practice offered longer appointments for patients with a learning disability.

Good



Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice had a relatively large amount of substance misuse patients and there were Drug and Alcohol workers attached to the practice three days per week, which allowed effective monitoring of these vulnerable patients. They worked in partnership with the lead GP who had the RCGP Certificate parts 1 and 2 in the management of drug misuse, providing three clinics a week. There were 34 patients on substitute medication that were being supported by the practice. These patients were reviewed on a regular rolling monthly cycle.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. We saw they would refer patients to other services such as Cognitive Behavioural Therapy (CBT).
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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

- There was a GP lead for dementia and they carried out advanced care planning for patients with dementia and had achieved 93% of the latest QOF points, which was above the CCG averages.
- 80% of the practice staff had received Dementia Friends training.
- The practice had double the national prevalence of patients with severe enduring mental health problems and many more with common complex mental illness. One hundred and forty eight had a comprehensive care plan and these patients were invited to attend annual physical health checks and 132 had been reviewed in the last 12 months
- They had mental health lead GP and there was a primary care mental health worker (PCMH) based at the practice one day a week whose role included supporting patients with mental illness transfer from secondary care back to primary care. There

Good



Summary of findings

were monthly reviews of all patients being seen by the PCMH worker with the lead GP. Patients were also referred to other services such as Back-on-Track and IAPT (Improving Access to psychological therapies) for CBT and counselling.

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice also provided support to three local mental health hostels. They had good working relationships key workers who could request appointments at suitable time for their clients.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing below or in line with local and national averages. There were 94 responses and a response rate of 22%, which was 0.6% of the practice population.

- 82% found it easy to get through to this surgery by phone compared to a CCG average of 75% and a national average of 73%.
- 85% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average 83% and a national average 85%
- 95% of patients described the overall experience of this GP practice as good compared to a CCG average 84% and a national average 85%
- 91% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to a CCG average 78% and a national average 85% 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 comment cards which were all positive about the standard of care received.

We spoke with five patients during the inspection. All said they were satisfied with the care they received and the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were satisfied with the care provided by the practice.

We noted that 91% of patient who had completed the friends and families test said they would recommend the practice.

North End Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and another CQC inspector.

Background to North End Medical Centre

North End Medical Centre provides GP primary care services to approximately 18500 people living in Hammersmith and Fulham, which is ten percent of the total population for the borough. The local area is a mixed community and there is a wide variation in the practice population, from relatively deprived to extremely affluent and mainly young to middle age.

The practice is staffed by ten GP partners. In addition there are five salaried GPs. There are five male GPs and ten female GPs who work a combination of full and part time hours totalling 80 sessions per week. The practice is a training practice and employs two trainee GPs. Other staff included a practice manager, a contracts and performance manager an Advanced Nurse Practitioner, two practice nurses, four Health Care Assistants, seven administrative staff, eight receptionist and two cleaners. The practice holds a Personal Medical Services (PMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice is open from 7.30am to 8.00pm Mondays to Fridays, except Thursdays, when they close at 7.00pm. They

also provided extended hours on a Saturday 8.00am to 1.00pm, which is particularly useful to patients with work commitments.as these appointments were prioritised for working patients. The telephones are staffed throughout working hours. Appointment slots are available throughout the opening hours. Longer appointments are available for patients who need them and those with long-term conditions. This also includes appointments with a named GP and nurses. Pre-bookable appointments can be booked up to two weeks in advance; urgent appointments are available for people that need them. Patients can book appointments online.

The practice provides a wide range of services including clinics for diabetes, chronic obstructive pulmonary disease (COPD), contraception and child health care. The practice also provides health promotion services including a flu vaccination programme and cervical screening.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 5 April 2016. During our visit we:

- Spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service.
- Reviewed policies and procedures, records and various documentation.
- Reviewed Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

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

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

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

- Older people
- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety.

- They had processes in place for documenting and discussing reported incidents and national patient safety alerts as well as comments and complaints received from patients. Administrative staff and receptionists were encouraged to report all incidents to the practice manager. They said they would have an initial discussion and agree any initial actions that should be taken. The practice manager told us they would then ask the staff to complete the incident form located on the computer shared drive. Staff we spoke with were aware of their responsibilities to bring incidents to the attention of the practice manager. They said they were always discussed at the weekly staff meetings. Minutes were also sent out to staff not present at these meetings.
- The practice carried out a thorough analysis of the significant events on a quarterly basis and sent annual reports to the CCG. They also discussed these at their weekly GP meeting and monthly locality meetings with other practices where action taken and lessons learnt were circulated.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw where a patient's medication was changed by the hospital, the pharmacist was not informed in a timely way, therefore continued to dispense repeats of the original medication. When this was brought to the practice's attention they sent a letter of apology and reviewed their processes to ensure that all GPs read and actioned all mail on a daily basis.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. All staff had received relevant role specific training on safeguarding adults and children. Clinicians were trained to level 3 and non-clinicians level 1. All staff we spoke with knew how to recognise signs of abuse, they were also aware of their responsibilities and knew how to share information, record and document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located on computer desk tops and displayed on the walls in reception and treatment rooms. Weekly child safeguarding meetings were held at the practice, which were attended by a health visitor and GPs from the practice. The lead GP attended all external safeguarding meetings.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If the practice nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role on occasions. All staff who acted as chaperones had received appropriate training. All staff we spoke with understood their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff providing these duties had been Disclosure and Barring Service checked. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. The practice completed a

Are services safe?

weekly infection control checklist and annual audits were undertaken. We saw evidence that action was taken to address any improvements identified as a result. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, and liaised with the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw the practice was performing below predicted prescribing costs. Records confirmed that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range of 2 to 8°C. There was a clear procedure to follow if temperatures were outside the recommended range. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a GP.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We saw the practice had risk logs that identified operational risk and

business risk. The risk assessment forms graded risks as major, moderate, minor and insignificant. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Portable electrical equipment testing (PAT) had been carried out in March 2016. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in had been carried out at the same time.

- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw that where they had an increase in patient numbers, both clinical and non-clinical staff numbers had also been increased. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty and we saw that across a twelve month period it took account of seasonal pressures, such as in the winter and after holidays. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The reception manager occasionally provided cover in reception when needed.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was a panic alarm system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

Are services safe?

- There was a defibrillator and oxygen with adult and child masks available. There was also a first aid kit and accident book.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were held off site by the practice manager and GPs. All staff we spoke with were aware of who to contact when key staff were off.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We saw the practice had weekly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The practice also developed clinical protocol links to these guidelines and referral pathways.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The practice manager would email and discuss any drug alerts received, at the weekly clinical meeting. They also ran quarterly audits to find out if any patients were still taking any of the drugs on these alerts. All GPs would review the use of the medicine in question and where they continued to prescribe it, recorded the reason why they decided this was necessary. The evidence we saw confirmed that all clinicians had a good understanding of best treatment for each patient's needs.
- These patients would be discussed at the meetings with clear explanation documented if they were to remain on these drugs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available with 25% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). We were told that level of

exception reporting was mainly due to vulnerable and disabled patients who had multiple morbidities that either prevented QOF monitoring or made it inappropriate, for example they had a high proportion/prevalence of mental health patients and these patients had poor compliance and poor attendance and both these factors had contributed to increased exception rates.

This practice was not an outlier for any QOF (or other national) clinical targets. The QOF data showed:

- Performance for diabetes related indicators was 100% which was 17% above the CCG and 11% above the national average.
- Performance for mental health related indicators was 99% which was 14% above the CCG and 6% above the national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes.

- There had been five clinical audits carried out in the last year. Two were completed where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, they received an MHRA alert about the potential for blood pressure rise in patients taking Mirabegron, a drug used to treat overactive bladders. We saw this was discussed with a prescribing advisor who felt that patients would need a Blood Pressure (BP) check every 6 months. All patients taking Mirabegron were audited to see if they had a BP done within the last 6 months. 22 patients were taking Mirabegron and only 50% (11) had a BP recorded in the last 6 months. After the initial audit they contacted all patients on this medication and advised them that they needed a BP check and educated them as to the potential side effects of the drug. The second cycle of the audit showed of the 16 patients identified still taking Mirabegron, 88% (14) had a BP check recorded in the last 6 months. There was evidence of improvement in the quality of care. In addition the practice had decided to place an alert in the electronic notes of all patients on Mirabegron to remind clinicians of the need for BP monitoring every time they entered the patient's record.

Are services effective?

(for example, treatment is effective)

- The practice attended a monthly locality meetings run by the CCG. Performance data from the practice was evaluated and compared to similar surgeries in the area.

The team made use of clinical audit tools and clinical meetings to improve performance. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved at their weekly clinical meetings. Staff spoke positively about the culture in the practice around audit and quality improvement.

Effective staffing

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

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety. The practice also had comprehensive induction packs for each role in the practice which were kept up to date.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff also completed regular mandatory courses such as annual basic life support and health and safety training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics.
- Staff told us that career development was a priority. They had access to additional training to ensure they had the knowledge and skills required to carry out their roles and staff were proactively supported to acquire new skills and share best practice. For example, receptionists had been trained to be healthcare assistants. The healthcare assistants were also being trained to carry out spirometry and ambulatory blood pressure monitoring (ABPM).

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and test results.
- All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. All vulnerable patients had care plans which they had been involved in drafting. They included information about how to manage their conditions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. The district nursing team were based close to the practice and would drop in to have ad hoc discussions with the GPs when they had serious concerns about patients.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.
- There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw evidence in patient records to confirm this.

Are services effective?

(for example, treatment is effective)

- The practice also documented in patients notes if they had refused a chaperone when offered.
- The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice hosted a smoking cessation clinic at the surgery and had received an award for being the Most Engaged Location in Hammersmith and Fulham (2015). Most of the reception staff were trained smoking cessation advisors and over the last financial year the practice referred 146 patients who signed up to the local Kick it service. Of these there were 97 quitters of which 60 were validated by Carbon monoxide testing after six months and 37 self-reported quitters. There were however 49 relapses.
- The practice hosted and provided onsite access to health trainers twice a week to advice patients on living healthier lives
- Drug and alcohol workers and a mental health support worker were available at the practice three days a week to provide additional support to patients.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%. The practice nurse told us they would contact women directly by letter and send text message reminders for patients and would follow up patients who did not attend for cervical screening.

Childhood immunisation rates for the vaccinations given were comparable to the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 71% to 89% and five year olds from 53% to 90%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice had received an award for their performance in providing NHS health checks to their eligible population. They had 29% achievement against a CCG area average of 20%.

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, fever in children and influenza. There was also information about local health and community resources.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The reception desk and waiting area were in separate rooms, which allowed patients to have conversations that could not be overheard from the waiting room.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The 10 patient CQC comment cards we received were positive about the service experienced. We also spoke with six patients on the day of the inspection and two members of the patient participation group. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were satisfied with the care provided by the practice.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2015, the practice's internal patient survey and the results from the NHS Friends and Family Test where 95% patients said they would recommend this practice.

Results from the national GP patient survey showed the practice was rated above local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them which was in line with the CCG average of 87% and national average of 89%.
- 85% said the GP gave them enough time which was in line with the CCG average of 84% and national average 87%.

- 98% said they had confidence and trust in the last GP they saw which was above the CCG average 95% and national average 95%.
- 88% said the last GP they spoke to was good at treating them with care and concern which was comparable with the CCG average 84% and national average 85%.
- 95% said the last nurse they spoke to was good at treating them with care and concern which was comparable with the CCG average 85% and national average 90%.
- 93% said they found the receptionists at the practice helpful which was comparable with the CCG average 85% and national average 87%.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff.

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

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 77% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average 79% and national average 81%.

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 patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations, including counselling, cancer support and bereavement services. The practice's website gave listings of all the support available in the GP surgery including carer services and mental health support, which could be accessed through self or GP referral.

The practice was proactive about supporting carers and had identified 101, including 3 young carers which was less

Are services caring?

than 1% of the practice patient population. They had attended additional training to help them implement appropriate systems for identifying and supporting patients with caring responsibilities. The practice manager told us that the low number of carers may be reflective of their population as they had a higher number of younger people or those who live alone. They said they encouraged patients who were carers to come forward through publicity and information kept on their website and provided information about additional organisations who provided support.

Staff told us that if families had suffered bereavement, their usual GP contacted them by phone and some would send a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

For example the practice attended a monthly network meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised. For example, local referral pathways for diabetes patients. The practice had also signed up for all seventeen 'out of hospital services' which included services such as spirometry, phlebotomy, ABPM and anticoagulation management.

- Patients over 75 years had a named GP to co-ordinate their care. Patients identified as needing extra time were flagged on the computer system and provided with a double appointment with on the day or planned home visits (GP) when required. They had identified that 7% of their older patients were at risk and all had care plans in place. Patients were referred to the older person's rapid access clinic and the practice used the virtual ward to prevent unnecessary hospital admissions. Patients in the group were also referred to their pilot social prescribing service for non-medical care needs. The practice utilised other support services, such as referring patients to a befriending service run by a local charity, the local Red Cross Services and Healthier Homes. (Healthier Homes is a Public Health funded project aimed at reducing GP appointments and Hospital Admissions. It focuses on the health effects of fuel poverty and hazards in the home.)
- The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. We saw all clinical members had completed further training in their areas of responsibility and acted as a source of information for other staff. For example, the diabetes lead had completed the 'merit course' (Meeting Educational Requirements, Improving Treatment) which is a flexible modular education programme that helps healthcare professionals to update and deepen their knowledge of diabetes treatment and care so they can better help their patients. They provided weekly dedicated diabetic clinics run by 2 GPs and a practice nurse who had also completed specialist training. They were able to initiate insulin and other injectable therapies such as GLP-1 (long acting glucagon) which meant patients did not need to go to community clinics or to secondary care.
- The practice also took part in a programme of Community Health workshops on diabetes, in partnership with a local voluntary agency. We saw these workshops included cooking demonstrations, sample recipes, medical and practical advice and a free diabetic-friendly lunch was also served. The workshops were delivered on a monthly basis and attendance ranged from 50 – 100 at each workshop.
- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. The practice had a designated palliative care lead providing continuity of care and end of life care planning. These patients all had a 'co-ordinate my care' record and were discussed at quarterly meetings with the community palliative care team. One of the practice GPs was the Macmillan Lead for Hammersmith and Fulham CCG.
- The practice provided dedicated COPD and Asthma clinics run by their trained nurse who performed spirometry and Peak Flow tests. These clinics were overseen by dedicated GPs (one each for COPD/Asthma) and their advanced nurse practitioner. Patients were given self-management plans including 'rescue pack' antibiotics and oral steroids. Patients in these groups had a care plan and would be allocated longer appointment times when needed. Reception staff supported clinicians in ensuring annual reviews were completed for all patients.
- One GP provided a medical acupuncture service which was offered for a range of conditions, including musculo-skeletal, tension headaches and migraines. The practice provided evidence that showed this GP had reduced referrals to MSK/ Neurology and Pain Clinic by 50% in the last twelve months.
- The practice held weekly baby clinics in conjunction with health visitors and there were systems in place for

Are services responsive to people's needs?

(for example, to feedback?)

identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, they had a named administrative staff member who monitored paediatric non-attenders to hospital out-patient and community services. The practice triaged all requests for appointments on the day for children when their parent requested the child be seen for urgent medical matters, thus were able to offer appointments at a mutually convenient times, for example after school, when appropriate. The practice hosted community clinics run by hospital teams such as sexual health and paediatric allergy clinics.

- The practice offered working age patients access to extended appointments six times a week which included weekend appointments. They offered on-line services which included appointment management, viewing patient records, repeat prescriptions and registration. They also had GP telephone triage for all requests for same day appointments, which enabled telephone and email consultations where appropriate, without patients having to take time off work. Pathology results were also sent by SMS texts as routine when patients had consented to receive results by text.
- The GPs told us that patients whose circumstances may make them vulnerable such as people with learning disabilities, homeless and substance misuse patients were coded on appropriate registers. Pop up alerts were placed on all computer notes to alert all members of staff to vulnerable patients. GPs told us this was to allow them to meet their specific additional needs such as double appointments, interpreter, visual/hearing impaired, carer details, and risk assessment stratification. Learning Disability patients were given care plans that met their needs. Patients with learning disabilities were invited annually for a specific review with their named GP, often on a Saturday when the practice was quieter. We saw 14 out of 17 reviews had been carried out in the last 12 months.
- The practice had a relatively large number of substance misuse patients and there were Drug and Alcohol workers attached to the practice two days per week, which allowed effective monitoring of these vulnerable patients. There were 34 on substitute medication that were being supported by these workers. Their role was to support these patients via holistic care plans that addressed areas such as drug use, criminality, housing and social functioning. We saw they would refer patients to other services such as Cognitive Behavioural Therapy (CBT). They worked in partnership with the lead GP who had the RCGP Certificate parts 1 and 2 in the management of drug misuse, providing three clinics a week. Patients were referred by the criminal justice system, the GPs or self-referral. Patients were reviewed monthly by the substance misuse workers and on a regular rolling three month cycle with the GP. We saw they also supported a number of patients, dependent on other commonly abused substances such as alcohol and benzodiazepines.
- The practice had double the national prevalence of patients with Severe Enduring Mental Health problems and many more with common complex mental illness. They had 270 patients on their register. One hundred and forty eight had a comprehensive care plan and these patients were invited to attend annual physical health checks and all had been reviewed in the last 12 months. There was a mental health lead GP and a primary care mental health worker (PCMH) was based at the practice one day a week. Their role included supporting patients with mental illness transfer from secondary care back to primary care. GPs could also refer new patients to them. We saw there were monthly reviews of all patients being seen by the PCMH worker with the lead GP. Patients were also referred to other services such as IAPT (Improving Access to psychological therapies) for CBT and counselling and voluntary organisations such as Back-on-Track and MIND. The practice also provided support to three local mental health hostels. They had good working relationships key workers who could request appointments at suitable time for their clients.
- There was a GP lead for dementia and they carried out advanced care planning for patients with dementia and had achieved 93% of the latest QOF points, which was above the CCG averages. GPs told us they proactively screen patients to identify those more at risk of or with Dementia and refer these patients to the memory clinic. They said they work with their dementia patients and their carers to develop care plans including early consideration of advanced care planning and power of attorney issues. 80% of the practice staff had received Dementia friends training.

Are services responsive to people's needs?

(for example, to feedback?)

- The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. Accessible toilet facilities were available for all patients attending the practice. They had access to interpreters when needed.

Access to the service

The practice was open from 7.30am to 8.00pm Mondays to Fridays, except Thursdays, where they closed at 7.00pm. They also provided extended hours on a Saturday 8.00am to 1.00pm, which was particularly useful to patients with work commitments. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP and nurses. Pre-bookable appointments could be booked up to two weeks in advance; urgent appointments were available for people that needed them.

They also provided a telephone triage service. This had reduced the need for patients to have a face to face appointment with a GP.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 86% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 82% patients said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average 73%.

- 72% patients described their experience of making an appointment as good compared to the CCG average of 70% and national average of 73%.
- 78% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63% and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. All verbal complaints were recorded on a spreadsheet.
- The practice managers handled all complaints in the practice. We saw that these were analysed on a quarterly basis and the outcome and actions were sent to all members of staff. We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last 12 months and found these were dealt with in a timely way, in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we saw that where patients had complained about the position of the TV in the waiting room the practice had repositioned the TV.

Are services well-led?

Outstanding



(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.

- The practice vision and values was to provide an environment which was welcoming, respectful, caring and accessible for all their patients. They said in order to achieve this they work with the CCG, other local practices and local health, social care and community organisations to improve the health and well-being of all their patients. All staff we spoke with knew and understood the vision and values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were monitored and updated bi-annually.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.
- The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff had to read the key policies such as safeguarding, health and safety and infection control as part of their induction. All six policies and procedures we looked at had been reviewed annually and were up to date.
- The contracts and performance manager was responsible for implementing and monitoring appropriate reporting systems to measure their QOF performance. The QOF data for this practice showed it was performing above national standards, however exception reporting was also higher than the national average. They had scored 839 out of 900 in 2014 and 553 out of 559 in 2015 which was 8% above the CCG average and 4% above England average. We saw QOF data was

regularly reviewed and discussed at the weekly clinical and monthly practice meetings. The practice also took part in a peer reviewing system with neighbouring GP practices in Hammersmith and Fulham.

- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records.

Leadership, openness and transparency

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

- When there were unexpected or unintended safety incidents, the practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us that the practice had weekly team meetings. We saw from minutes that these meetings were also used for training and updates.
- Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. They felt they worked

Are services well-led?

Outstanding



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

well together and that they were a highly functional team which listened and learnt, and were aware of the challenges to their service such as a reduction in income against an increasing list size.

- We noted that team away days were held every year and staff told us these days were used both to assess business priorities and socialise with colleagues.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff said they felt respected, valued and supported, particularly by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, last year's survey had identified concerns about the length of time it took to answer the phones on some occasions. As a result the practice had installed a new phone line to support incoming and outgoing calls and had increased reception staff at certain times.
- The practice manager had monthly sessions where they met with patients to discuss any concerns, feedback or resolve any complaints.
- The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff at all levels were actively encouraged to raise concerns. All staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice and the practice team was forward thinking. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. The practice took part in local pilot schemes to improve outcomes for patients in the area. For example, the practice worked in partnership with a local charity and had appointed a social prescriber to provide non-medical support to patients. Patients were referred to them by the GPs and their role included either providing direct support themselves or referring patients to other services for support around social isolation, mental well-being, housing and benefit maximisation. We saw three examples of where patients had been referred to this service and, once their social care needs had been addressed, there were improvements in their health conditions.

The practice was also a training practice and two GP partners were qualified trainers. At the time of our inspection they had just appointed two trainees. Four partners were also GP teachers and taught medical students studying to become GPs. Further, the practice initiated and hosted weekly lunch time teaching events delivered by consultants which was open to other local practices and all the clinical staff at the practice including the nurses.

A systematic approach was taken in working with other organisations to improve care outcomes and tackle health inequalities. All partners were involved in various external boards and organisations such as CCG and Hammersmith and Fulham GP Federation. The practice manager led and facilitated the practice manager forum. We saw that information from all these forums were fed back to practice staff at the weekly practice meetings.

The practice also took part in various pilots and had a history of testing out new ways of providing a service such as they had implemented online access since 2006 and we saw that 27% of their patients were signed up and regularly used online services. They had also been providing extended opening hours since 2009.