

Sudbury and Alperton Medical Centre

Quality Report

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Date of inspection visit: 29 October 2014 19
November 2014
Date of publication: 09/04/2015

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

Ratings

Overall rating for this service		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?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Sudbury and Alperton Medical Centre provides a GP service to approximately 8027 patients in Brent. Sudbury and Alperton Medical Centre is based at two locations (branches), Ealing Road, Brent and Watford Road, Harrow. We visited the Brent location as part of this inspection.

We carried out an announced comprehensive inspection of Sudbury and Alperton Medical Centre on 29 October 2014 and 19 November 2014 (PM). Overall the practice is rated as good. Specifically, we found the practice to be good at providing well-led, safe, effective, caring and responsive services.

Our key findings were as follows:

- Patients were overall satisfied with the service. They said the staff were able to get an appointment within a reasonable time, staff involved them in decision making about their care and were kind and respectful.
- Medicines were managed safely and infection control measures were in place.
- Staff were suitably qualified and received sufficient training to meet patients needs.
- The practice sought feedback from patients and staff and acted on it to improve the services provided.

However, there was one area where the provider needed to make an improvement.

An automated external defibrillator should be available for medical emergencies.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

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 that the practice responded quickly to issues raised.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received regular performance reviews and attended staff meetings and events.

Good



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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Telephone consultations and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



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, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Good



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 this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had a range of health promotion and screening that reflects the needs for this age group.

Good



Summary of findings

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 with a learning disability and carried out annual health checks for these patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients how to access various support groups and voluntary organisations. 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.

Good



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). The practice had reviewed the care offered to people with dementia as part of an audit. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out care planning for patients with dementia.

The practice had a system in place to follow up patients who had missed GP appointments and secondary care appointments with mental health services where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We spoke with seven patients during the course of our inspection. We reviewed the results of the practices most recent experience survey and the 2014 national GP Patient Survey. We reviewed 41 patient comment cards and one letter where patients had shared their views and

experiences of the practice. Patients said that they were mostly able to get an appointment within a reasonable time. Patients said they were given time to talk during their consultation, they were involved in decisions about their care and they were satisfied with the care provided.

Sudbury and Alperton Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Sudbury and Alperton Medical Centre

Sudbury and Alperton Medical Centre provides services from 267 Ealing Road, Wembley, HAD 1EU and 228 Watford Road, Harrow, HA7 3TY. We visited the Ealing Road branch of the surgery. The staff, including the GPs work at both branches.

The practice provides primary medical services through a General Medical Services (GMS) contract. A GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. Approximately 8027 patients are served by the practice in the local community. The practice is part of NHS Brent Clinical Commissioning Group (CCG) which is made up of 67 GP practices. The majority of patients registered at the practice were between the ages of 25-34.

The service 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 offers extra services to patients including phlebotomy (taking blood), ECGs, 24 hour blood pressure monitoring (whereby patients are monitored on two consecutive days) and spirometry (lung capacity measurement).

The practice staff team consists of five GP partners, two male and three female. The practice does not have a practice manager and there were no plans to appoint a practice manager. The GPs manage the practice between them and have designated managerial tasks in addition to their medical practice. A practice nurse and a phlebotomist were employed at the practice.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

Detailed findings

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.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 October and 19 November (PM). During our visit we spoke with a range of staff including GPs, the practice nurse, and reception staff. We spoke with a group of seven patients who represented the PPG. We reviewed comment cards where patients shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We looked at four incidents which been recorded since the beginning of 2014.

The incidents were documented with the action the practice had taken to minimise the risk of a recurrence. An example of this was a patient reporting that a clinician had difficulty 'taking bloods'. As a result of this incident the practice extended the hours that the phlebotomist worked. The purpose of this was to ensure these appointments were not rushed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff used incident forms on the practice intranet. We tracked four incidents and saw records were completed in a comprehensive and timely manner.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of hours. Contact details were easily accessible, for example child protection information, with local contact numbers was on display in the reception area.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. The lead had

been trained and could demonstrate they had the necessary training to enable them to fulfil this role. The safeguarding lead explained that in the event of a safeguarding concern a practice meeting was planned and all the staff were informed of the case, to ensure the staff team had the information they required. GPs had received child protection training to Level 3, nurses to Level 2 and non clinical staff to Level 1. Staff had received training in safeguarding vulnerable adults. A link was available on the desktop computer with key telephone numbers for reporting safeguarding concerns. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

Patients were made aware of the availability of chaperones by means of notices displayed in consulting rooms. In the event of a patient requesting a chaperone during treatment, a practice nurse would act as a chaperone. Training and guidance was provided for the practice nurse who undertook the role of chaperone. All staff at the practice had a Disclosure and Barring Service (DBS) check.

Medicines management

We checked medicines and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice had a separate fridge to store vaccines and the temperature was checked daily by the nurse. The records we saw evidenced that the temperatures were recorded daily for the vaccine fridge and the specimen fridge. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

All prescriptions were reviewed and signed by a GP on duty before they were given to the patient. Where patients required repeat prescriptions an alert was placed on their patient record as a reminder to invite them to make an appointment for a medication review.

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place. A record was kept of the daily check which was made by staff on the standard of cleaning in all areas of the practice. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the last infection control audit cycle had been carried out between 2012 and 2014. As a result of the first audit it was identified that a 'sharps injury' poster should be displayed. This action had been subsequently taken by the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including 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. There was also a policy for needle stick injury. The practice had completed a 'Sharps' audit which looked at the safe management and disposal of used syringes.

Notices about hand hygiene techniques were displayed in toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example weighing scales and the fridge thermometer. We saw evidence that equipment testing and calibration took place in March 2014.

Staffing and recruitment

We looked at the recruitment records of two clinical members of staff and one non clinical member of staff. These contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This had been reviewed and updated in July 2014.

Staff told us about the arrangements for planning and monitoring the number and skill-mix of staff needed to meet patients' needs. For example, there was a rota for the two practice nurses who worked on set days of the week. The team of GPs worked across both sites of Sudbury and Alperton Medical Centre. There was a rota system in place for all staffing groups to ensure there were enough staff on duty. The rota ensured patients had the choice of a male or female GP every day at each site.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at team meetings.

The practice informed us that there was an emergency care pathway for patients with mental health problems. Staff explained that if a patient in this category missed an arranged appointment the practice would contact them to follow up their care and the reasons for the missed appointment. In the event of a patient deteriorating or having a mental health crisis, a referral was made for an assessment with a duty psychiatrist. Patients who presented with psychological problems had the option of being referred to the assessment and brief treatment team. Where patients had been referred to Improving Access to Psychological Therapies (IAPT) or for counselling the GP would contact them if these appointments had not been attended.

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in 2014. Emergency equipment was available including access to oxygen. The practice did not have an automated external defibrillator. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice had a comprehensive list of policies in the document management folder. Staff informed us they were able to access these policies and procedures for their guidance.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this had happened.

The practice uses a central referral management system to make patient referrals to secondary and other community care services. When a locum GP made a referral the referral information was copied to one of the partner GPs for his or her assessment and verification.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us eight clinical audits that had been undertaken in the last three years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. The practice had reviewed the prevalence of coronary heart disease (CHD) in their patient group and had updated their patient record system to ensure patient records were accurate. An audit cycle had also been completed on the prevalence of Chronic Obstructive Pulmonary Disease (COPD). The prevalence of COPD had increased from 3.37% to 4.87%. An action plan had been drawn up as a result of this audit cycle. This included training five GPs, three nurses and one health care assistant in spirometry (a breath test to measure the size of the patients lungs). Asthmatic patients who were known to smoke were offered spirometry testing and the COPD register was updated as necessary.

An audit cycle to identify the prevalence of dementia had been completed. The prevalence of dementia had increased from 1.5% to 2.8%. As a result of the audit clinicians had attended training to help them identify patients with dementia and some patients were offered dementia screening. Where necessary a referral was made to the Brent Memory Clinic.

Other audits had been commenced. These were audits on repeat prescribing and the prescribing pattern of specific medicines, for example laxatives, nutritional supplements and 'silver' dressings for wound care. The cycle of these audits was due to be completed in December 2014.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. The practice had achieved a total of 95 QOF points out of a target of 100.

Effective staffing

Are services effective?

(for example, treatment is effective)

Practice staff included medical, nursing, and administrative staff. We reviewed training records and saw that staff were up to date with attending mandatory courses such as annual basic life support, infection control and child protection. All staff had a training record and we saw that practice nurses had a record of their skill updates and study days, for example, on diabetes, cytology and immunisations. Practice nurses had received 'in-practice' training in asthma and COPD, hypoglycaemia awareness and cardiology.

GPs had attended a two day training session in the Mental Capacity Act and Gillick Competency, provided for GPs working within the Brent locality GP network. The senior partner had attended an NHS workshop on understanding learning disabilities.

The two phlebotomists had received mandatory training at an NHS Hospital which included health and safety, safeguarding children and adults, infection control, basic life support. The phlebotomists' had been trained in phlebotomy within a hospital setting.

Non-clinical staff had received training in managing the information system used at the practice, infection control and basic life support. Their training plan recorded they had been booked onto child protection training in October 2014. The practice later confirmed that staff had attended this training on the 22 October 2014.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

The staff were appraised annually by the GP partners. Staff had identified their training as a development need which was agreed by their appraiser. We looked at the training folder of one member of staff and saw that training had been undertaken as identified in their training and development plan.

We saw evidence of GP 360 degree feedback. This is a method of performance appraisal whereby patients and colleagues give their feedback on the individual clinician's

skill. The purpose of this was to highlight and promote areas for improvement. The four main areas where GPs had been assessed were skills and knowledge, safety and quality, teamwork and maintaining trust.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse said she attended the Brent CCG nurses forum where she was able to update her knowledge regarding matters relating to her role at the practice.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases.

The practice had a contract with the out of hours provider for patients. A specific form was used to communicate patients details to the out of hours provider. For patients receiving palliative care the practice wrote to the out of hours provider to ensure their care information was handed over accurately.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by district nurses, social workers and palliative care nurses. Decisions about care planning were documented in a shared care record.

Practice meeting minutes were reviewed. We saw that the staff team discussed significant events, complaints, and infection control. The clinical governance meeting minutes were also reviewed and there was evidence of discussion regarding partnership agreements.

Staff at the practice ensured patients had continuity of care. Practice nurses booked their patients to see them for follow up visits at the end of each consultation. An example of this was the treatment of patients who needed a wound dressing and babies/children who were due to have their immunisations.

The practice nurse used a 'communication book' for messages and updated individual records with information on the patients most recent appointment. The practice nurse we spoke with said she liaised with the tissue viability nurse and discussed patient care with the GPs at the end of each surgery.

Are services effective?

(for example, treatment is effective)

The GPs also attended CCG network meetings with other GPs for the Brent CCG. Patient case studies could be submitted for discussion, the aim of this was to improve patient care and share learning. Specialists were invited to meetings to give advice and support, for example, psychologists, elderly care workers, palliative care nurses and specialists in cardiology and diabetologist (radiation biology).

Information sharing

The practice had an electronic system to communicate with other health care services and provide staff with the information they needed.

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

All staff attended regular team meetings where they were updated on developments. The last two team meetings had taken place in June 2014 and August 2014. The topics discussed included care planning and hospital admissions, staff rotas, significant events and complaints. A teaching session on immunisations had been given during the August 2014 meeting.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and had knowledge of Gillick competency assessment of children and young people. Gillick competence is used to determine whether a child (16 years or younger) is able to consent to his or her medical treatment.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was in line with the CCG average for childhood immunisations for children under 12 months, 24 months and five years.

A clinic was held every Monday for childhood immunisations and sexual health. The clinic was led by a female GP, and patients were able to make a 'same day appointment'. In the case of childhood immunisations, where a baby or child had recently moved from another country, their immunisation programme was initiated again if there was no immunisation record from their country of origin.

The practice had exceeded their target for the uptake rate for Cervical smears. This stood at 81% with the CCG target set at 80%.

Patients over the age of 75 had a named GP. There was an alert on the patient recording system which prompted reception staff to make a same day appointment for patients in this category.

Patients with long term conditions such as asthma or diabetes were able to book an appointment with the practice nurse for treatment. There were no specific scheduled clinics for the treatment of individual long term conditions.

The practice was one of three in the Brent Locality who met on a quarterly basis to review and discuss patients who were receiving palliative care. This peer review process ensured that the care of palliative care patients was being monitored for best practice.

The practice was able to refer patients, who had agreed to a weight loss programme to a local leisure centre for exercise and to a nationally established commercial slimming programme. Four patients had been referred to these services.

The practice held a register of those in various vulnerable groups (e.g. homeless, travellers, learning disabilities).

Are services effective?

(for example, treatment is effective)

The practice had identified patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. There were 17 patients on the register and fourteen of these had received an annual physical health check. There was a link to the carer support form inserted into the patient record to identify the patient and their carer if this was applicable.

There was evidence of MDT working in case management of vulnerable groups. We were informed by staff that 'coordinate my care' forms for multi-agency working was being developed by Brent CCG.

The practice had a 'pathway' for managing the care of patients who experienced poor mental health and psychological problems. Patients who were experiencing poor mental health were monitored by their GP and referred for an assessment if their health changed or their condition deteriorated. Patients who missed an appointment would be contacted by their GP for a follow up. People experiencing psychological problems for, example anxiety disorders and stress, were referred to the assessment and brief treatment team who would then recommend a care pathway.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey, a survey of 136 patients undertaken by the practice, and a survey undertaken by the practice with the PPG. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

The results of the 2014 national GP Patient Survey showed that the practice was in line with the CCG average when it came to patients being treated with care and concern by the practice nurse and their GP. Information from the practice GP survey indicated that 79% of patients would either definitely or probably recommended the practice to others.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 41 completed cards and one letter. The majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Patients said that the staff at the practice responded to their needs and acted promptly when a referral was needed for diagnostic tests. We received comments from two patients with 'caring' responsibilities for members of their family who were vulnerable. The respondents said they were given an emergency appointment, home visit or access to a GP telephone consultation when they needed to discuss the welfare of their relative.

Three comments which were less positive referred to a patient experience of waiting times once at the surgery, the open reception area, and seeing a different GP on two occasions for the same condition.

We also spoke with a group of seven patients on the first day of our inspection. The patients were members of the Patient Participation Group (PPG). In response to patient comments regarding difficulty getting through to the practice during peak times, the practice increased its reception staff to three during the morning session.

Patients said that telephone consultations appointments were available daily and this would often involve the patient being telephoned by the GP. Patients commented that receiving information via text was useful.

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 room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89 % of practice respondents said the GP involved them in care decisions, treatment and results.

The survey carried out by the practice indicated that 91% or respondents said that their GP was good or very good at giving them enough time during their consultation, and 74% of patients said the their GP was good or very good at involving them in their care. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patients who completed comment cards and patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff at the practice spoke the following languages, Gujarati, Hindi, Urdu, Tamil, French and English and were available to support patients with communication if this was requested. An interpreting service was available for patients who were hard of hearing or required language interpretation. In addition to this patients could be supported by a friend or relative if they wished.

Are services caring?

Patient/carers support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and

provided support when required. Two patients who gave us their view by completing a comment card and writing to us, were very positive about the support they received from the practice during their difficult circumstances.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, their usual GP contacted them. Patients who required counselling were referred to external agencies for this.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had a system of ensuring patients had a named GP to facilitate the continuity of their care. However, staff informed us that patients still had a choice of GP and could request to change their GP if they wished to. An example of this was given, whereby a GP in the practice had taken over the care of a patient as a result of the patient requesting this.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The most significant change had been to the number of reception staff on duty during peak hours in the morning.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We were informed that staff at the practice spoke a number of local community languages and this enabled them to speak with the majority of their patients in their primary language.

There was no designated parking for people with a disability; the practice acknowledged this was difficult for some patients. At the time of the inspection a request had been submitted to Brent Council for a designated parking bay adjacent to the practice.

The practice was situated on the ground and first floor of the building with most services for patients on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities and baby changing facilities were available on the ground floor.

Access to the service

Access to the service was available from 8:30 to 18:45 and appointments were available from 9:00 to 12:00 and 16:30 to 18:30 Monday to Friday. When the practice was closed an Out Of Hours service provider was used. Information on this service was available on the practice answering machine. Extended appointments were available from 7:30 to 8:00 on Thursdays and 18:30 to 19:00 on Tuesdays.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. Appointments were bookable by telephone or in person. Patients could book an appointment one day in advance. Emergency appointments were bookable on the day and we were informed by reception staff that these were available prior to the practice closing, with patients being given an appointment with a GP towards the end of the day.

The results of a survey conducted by the practice indicated that patients found it difficult to 'get through' to reception staff by phone. As a consequence of this the practice had increased the number of reception staff answering the phone during the busy period in the morning. The practice had a total of four receptionists (two at each branch) to take telephone calls. A queuing system was being operated with patients being informed of their position in the queue. Patients were able to phone the practice to book a telephone consultation with one of the GPs. Two telephone consultations were available daily between 12.00 and 12.30.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Where a patient required immediate psychiatric support they were referred to the emergency psychiatrist or the emergency psychiatric duty team.

Listening and learning from concerns and complaints

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

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. There was a designated responsible person who handled all complaints in the practice.

We saw that there was a complaints poster in the reception area to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at complaints received in the last last twelve months. All three complaints recorded had been investigated and resolved in line with the practice's

complaints policy. The senior partner looked at complaints and signed them off once they had been investigated. There were no outstanding complaints at the time of the inspection.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last year from October 2013 to October 2014; no themes had been identified. Lessons learned from individual complaints had been acted on. For example, the practice ensured that that a named GP only, issued a repeat prescription for a particular patient. There was evidence of shared learning from complaints.

Staff team meeting records for June and August 2014 showed that complaints had been discussed.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The vision of the practice was to provide care in a clean, well equipped and suitable environment, to improve patients lives and involve them in decision making regarding their care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures which were on the practice intranet. Policies we reviewed were diverse and included Mental Capacity Act policy, whistleblowing policy, safeguarding policy (incorporating children, adults, domestic violence and mental health) and environmental policies such as infection control and waste management.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with staff and they were all clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, in ensuring patients who have dementia or CHD are recognised and treated by competent clinical staff.

Leadership, openness and transparency

The senior partner was due to retire in 2015. One of the existing GP partners who had been identified as the senior partner had undertaken training to take on specific responsibilities, for example in child protection. Arrangements had been made for the senior partner to hand over the senior role to his successor. This was evident during our discussion with the partners who worked jointly throughout the inspection.

Another partner at the practice was due to take maternity leave. The practice had secured a locum GP to cover the period of maternity leave. The locum GP has been working at the practice prior to the partner's maternity leave to enable her to become familiar with the work at the practice and for her competency to be assessed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, and complaints received. Minutes of the March 2014 PPG meeting identified that the results of the annual patient survey for the period 2013/14 had been discussed.

Improvements had been made as a result of feedback from patients. These were obtaining more reading material for the waiting room and a request for road side Disabled Parking to be made to Brent Council. The practice and the PPG had also identified that representatives from various population groups for example younger patients, needed to be recruited to the PPG. A large poster had been displayed in the waiting area advertising the PPG.

We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The PPG met three times a year and the meetings were arranged and facilitated by the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan.

Staff at the practice attended a number of meetings where patient care, service development and practice updates were discussed. GPs met with healthcare professionals at multi-disciplinary team meetings and with peers at the local CCG meeting. All of the staff met regularly to discuss the management of the practice and the care of patients.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings to ensure the practice improved outcomes for patients. For

Are services well-led?

Good 

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

example, the practice had reviewed how staff communicated with patients about the complaints procedure. As a result of this staff were updated on how to manage complaints.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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